U.S.

REPORT OF SPECIAL COMMISSION OF CIVILIAN PSYCHIATRISTS COVERING PSYCHIATRIC POLICY AND PRACTICE IN THE U.S. ARMY MEDICAL CORPS, EUROPEAN THEATER, 20 APRIL TO 8 JULY 1945

THE COMMISSION WAS SENT OUT UNDER THE AUSPICES OF THE FIELD SERVICE OF THE O.S.R.D. AT THE REQUEST OF THE NEUROPSYCHIATRY CONSULTANTS DIVISION, OFFICE OF THE SURGEON GENERAL

REPORT OF PSYCHIATRIC MISSION O.F.S. O.S.R.D.
EUROPEAN THEATER OF OPERATIONS

16 April 1945 - 16 July 1945

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The Commission: Doctor Leo H. Bartemeier
Doctor Lawrence S. Kubie
Doctor Karl Menninger
Doctor John Romano
Doctor John C. Whitehorn

I. INTRODUCTION

A. General Nature of Assignment or Mission.

To investigate "combat exhaustion" and related aspects of military psychiatry.

B. Military Command or Other Agency Requesting it.

Commanding General, European Theater of Operations (See memorandum of 12 April 1945 from Brigadier General William A. Borden, U.S.A., Director, New Developments Division, War Department, Washington, D.C.)

C. Military Commands with Which the Mission Work Was Carried Out.

American Commands:

Office of The Chief Surgeon, ETO (Division of Professional Services, Branch of Psychiatry); Commanding Generals and Surgeons of the 9th, 1st, 3rd and 7th Armies.
Various hospitals in the Zone of Communications.

British Commands:

Directorate of Psychiatry, Director General, Medical Services of the British Army;
Division of Neuropsychiatry, Admiralty Medical Board;
Division of Neuropsychiatry, Medical Directorate, Royal Air Force, Medical Department;
Ministry of Health, Emergency Medical Service.

D. Names of Members of Mission.

Leo H. Bartemeier, M.D.
Lawrence S. Kubie, M.D.
Karl A. Menninger, M.D.
John Romano, M.D.
John C. Whitehorn, M.D.

E. Objectives:

Principal: To explore the psychodynamics of psychiatric casualties as related to combat, to formulate concepts concerning these conditions and to suggest policies and procedures by which to apply or to test these concepts.

Secondary: In pursuing these objectives certain questions have been formulated:

1. To what extent are these psychiatric casualties determined by variations in personality structure, conditions of combat, military organization, procedure, treatment and other features of the situation under which they arise?

2. To what extent and in what manner can the occurrence of these psychiatric casualties be anticipated and prevented through selection, training, emotional preparation and the management of officers and men in the field?

3. How effective for military purposes are the treatment programs at various military levels?

4. What are the advantages and disadvantages of the term "combat exhaustion" at the battalion aid station and elsewhere, and can a better term or terms be used?

WORKING PLANS AND ACKNOWLEDGMENTS

The circumstances relating to the appointment of this Commission might be reviewed briefly as follows:

In the course of the development of the military campaigns of World War II, it soon became apparent that psychiatric problems were taking a place of increasing importance. Not only was the manpower problem affected, but the medical resources of the Army were severely taxed by the large number of psychiatric casualties. It has been said that as tuberculosis accounted for the highest percentage of medical casualties in the First World War, so psychiatric problems have proved to be the largest single category of disability discharges in World War II.

The scientific study of psychiatric casualties has had to depend upon the observations of very busy medical officers relatively close to the front lines of battle whose occupation with practical problems necessarily limited the amount of time they could give to the study of individual patients. As stated in a letter from The Surgeon General's Office in the United States to Major General Paul R. Hawley, Chief Surgeon in the ETO: "There is general agreement that there may be some important and essential difference in the psychopathology manifest in acute combat casualties from that evidenced in the typical psychoneurotic reaction. The clinical picture seen at the clearing station level changes within a few days, even hours, as the soldier is evacuated further to the rear. Because an accurate knowledge of the pathology is necessary to guide and plan the most effective treatment, it would seem important to attempt an evaluation of the psychopathology as observed at this forward echelon for the purpose of correlating it with subsequent treatment methods... It is obvious that the psychiatrists in the Army, and particularly the group at these combat levels do not have time and are not necessarily professionally equipped to undertake any such research. This suggestion (that these cases might be studied by a Commission of civilian psychiatrists) has met with the complete approval of the Office of Scientific Research and Development and the strong indorsement of Brigadier General W. A. Borden of the New Developments Branch, War Department".

General Hawley courteously extended an invitation for a Commission to be sent to the European Theater of Operations. Under the direction of the Committee on Medical Research of the Office of Scientific Research and Development (Doctor E. C. Andrus, Chief, Division of Medicine), a commission of five civilian psychiatrists, recommended by Colonel William C. Menninger and associates of the Office of The Surgeon General, was prepared for overseas assignment on this project and was sent out under the joint auspices of the Office of Field Service O.S.R.D., and the New Developments Division, War Department Special Staff.

The Commission departed from the United States on 20 April 1945 and followed the itinerary hereto appended as a part of its official report. According to the original plan of operation, the members of the Commission were to proceed in pairs or individually to different active fronts to study cases of "combat exhaustion". In Paris we learned that the military situation was somewhat different from what we had anticipated. There no longer existed any steady military fronts. In accordance with the advice of Colonel Lloyd J. Thompson (Senior Consultant in Neuropsychiatry, Office of The Chief Surgeon), and Colonel Ernest Parsons, we remained in one group and travelled in two CR cars to various army headquarters and some of their forward medical installations. Colonel Parsons escorted and guided us during the first three weeks of our travel. All army installations received the Commission with the greatest hospitality and welcome, and no difficulties of any kind arose from this quarter.

In the pursuance of the specific research assigned to the Commission, certain general and certain specific difficulties were encountered which should be mentioned. In a general way the Commission felt handicapped very greatly by the obvious fact that military combat situations such as those to which psychiatric casualties had been exposed were of so unique a quality and of so great an intensity as to make it difficult for anyone who had not actually had such experience to comprehend them fully. This is in marked contrast to the situation in civilian practice where, in most instances, a doctor is roughly familiar and at least generally conversant with the factors involved in the past history of his civilian patients. Furthermore, the members of the Commission found a certain difficulty making proper allowances for the fact that in their professional experience the relationship between physician and patient was a very different one from that which prevails in the Army. The civilian patient goes to the physician of his choice when he wants to and only when he wants to for a condition of which he complains or suffers (to be sure some psychiatric patients are brought by relatives, but here the latter are acting for the patient). In the Army, the patient does not usually come to the psychiatrist; he is sent. He has no choice as to physician or as to treatment. He cannot refuse treatment of any kind. The object of the physician in civilian life is to get his patient well for the patient's sake and for the sake of relatives; the object of the Army physician is to get his patient well enough to return to combat duty.

The more specific difficulty encountered by the Commission related to the sudden change in the military situation with the corresponding change in the incidence of acute casualties. The Commission arrived in the ETO when most of the fighting was over

and the expectation of victory was in the air. This situation led to such a marked diminution in the number of cases of combat exhaustion that the original plan of the Commission to study patients at clearing stations had to be abandoned.

In contrast to the disadvantages just mentioned, it might be appropriate to mention certain advantages enjoyed by the Commission in the pursuance of its investigation. First in importance should be put the cooperative spirit of all members of the Army Medical Department and the helpfulness of both American and British psychiatrists in seeking to place at our disposal all their data and whatever patients they thought might be suitable for our study. Our being civilians facilitated the obtaining of information from some patients. It also enabled us to identify ourselves very readily with either privates or officers, non-commissioned or commissioned men, because we were not, in fact, in any one of these positions ourselves. Furthermore, we escaped some of the features of the situation peculiar to the Army. We were not under any compulsion or obligation to find ways of getting men back to duty. It was our function only to study the conditions without the necessity of serving any utilitarian purpose by which Army doctors are always bound and constrained. We came to our study of psychiatric casualties mentally fresh and without the physical and mental fatigue which was evident in many army psychiatrists. By travelling from one medical installation to another and by conferring with many doctors it was like seeing the problem through many eyes so that individual blind spots and prejudices were cancelled out to some extent.

Although the Commission was particularly interested in all data pertaining to combat exhaustion, the incidence of this condition can only be approximately estimated because of the many variables in collecting statistics in the Army. Many soldiers returned to combat after being treated at battalion aid stations, for example, for whom no clinical records were made. How many of these presented the clinical manifestations characteristic of combat exhaustion cannot be determined, but it is certain to have been a large percentage. In the second place, we know that combat exhaustion occurred in waves directly related to certain military operations. Large numbers of these cases were received at medical installations during the fighting in the hedgerows in Normandy, in connection with the battle of the Hertgen Forest, the crossing of the Moselle, the offensive in the Ruhr, etc.

Among the most recent statistics which the Commission have were those presented by Colonel Lloyd J. Thompson, and Colonel W. S. Middleton, at a meeting with Major General Paul R. Hawley, The Chief Surgeon, and his consultants in Paris on 24 May 1945. The

Commission attended this meeting and learned that 80% of all NP cases in ETOUSA had been returned to various kinds of military duty. Perhaps even more dramatic was the report from one of the special U.S. military hospitals to the effect that 5,000 men were returned to some kind of military duty from one installation during the period of one year. If these thousands had not been treated they would have presumably been lost to the theater and would have returned home chronically ill. It is the opinion of the Commission that this report is a high tribute to the effective work of army psychiatrists.

The Commission wishes to make acknowledgement of indebtedness and assistance to the following persons:

Colonel William C. Menninger, Office of The Surgeon General;
Dr. Lincoln R. Thiesmeyer, O.F.S., O.S.R.D;
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ITINERARY

(For Detailed Itinerary See Appendix A.)

20 April	Washington to Paris
21-24 April	Paris
25 April	Paris to Verdun
26 April	Verdun to Aachen, Germany
27 April	Aachen to Munster
28 April	Munster to Braunschweig
29 April	Braunschweig to Calbe
30 April	Calbe to Braunschweig
1 May	Braunschweig
2 May	Braunschweig to Weimar
3-5 May	Weimar
6 May	Weimar to Erlangen
7 May	Erlangen to Regen
8 May	Regen to Susice, Czechoslovakia to Titling, Germany.
9 May	Titling - Salzburg - Munich - Augsburg
10 May	Augsburg
11 May	Augsburg to Luneville, France
12 May	Luneville to Ciney, Belgium
13-19 May	Ciney
20 May	Ciney to Paris
21-28 May	Paris
29 May	Paris to London

30 May	London
31 May	London-Stafford - Malvern
1 June	Malvern - Oxford - London
2-5 June	London
6 June	London to Brimingham (Northfield)
7 June	Birmingham to London
8-9 June	London
10 June	London to Edinburgh
11 June	Edinburgh - Callandar - Bellsdyke - Edinburgh
12 June	London
13 June	London - Chatham - London
14 June	London - Oxford - London
15 June	((J.R.) London - Bristol - London)
16-29 June	London
29 June-6 July	Paris
6 July-8 July	Paris to Washington
8 July - 16 July	Washington

SOCIAL AND PSYCHOLOGICAL FORCES AFFECTING THE COMBAT SOLDIER

It is our belief that one cannot understand fully the psychopathology of "combat exhaustion" without a previous understanding of the various background factors, social and psychological, which modify and determine the preparation of the soldier and his performance in combat warfare. To this end, it would appear wise to consider these factors as they relate to the cultural milieu from which the soldier comes to the period of military training and finally to the combat period.

CULTURAL MILIEU

For working purposes it can be assumed that the soldier inducted into the Army is one who has adjusted himself to internal and external stresses with a fair degree of personal comfort and social acceptability, and has shown himself capable of enduring some temporary increases in either the internal or the external pressures, or both, without untoward reactions. A working psychic equilibrium is maintained. Induction into the Army, habituation to the Army regime, and training in Army techniques and ideals involve very considerable alterations in the balance of forces by which an individual maintains this psychic equilibrium. This is particularly true when, as in the present war and in the United States Army, the vast majority of these men are inducted without strong conscious desire for Army life or for combat experience. Some of them are, in military terms, "deficient in motivation". They are motivated by a wish to comply with the demands of their country that they do their share in a disagreeable and dangerous task, and not by impulses of revenge, fear and hate, as one may suppose exists in the Russian soldier whose family has been slaughtered or the English soldier whose home has been destroyed.

Social factors which may contribute to the understanding of the American boy's motivations include the following: the American boy has been brought up to demand respect for his own individuality and independence, to assume his right of self-expression without limitations of caste or authority. He has been taught a code of behavior characterized by what is called "sportsmanship"; he believes in fair play, he does not hit a man who is down or one who is weaker; he does not hit "below the belt". He has grown up in a period of disillusionment. He has lived through years of economic depression and social change, a period in which war, patriotism, atrocity tales and world peace organizations were repetitively debunked and depreciated. Finally, he has lived in a country which for a number of years has evaded facing realistically and directly the gathering momentum of world disorder.

TRAINING PERIOD

Obedient to social pressure and government order, the soldier enters a training program constructed on the assumption that the ostensibly normal man has a sufficiently elastic personality structure to readjust himself to it without unendurable pain, effective protest or break. The statistical evidence bears out this assumption. In spite of the many rejections by induction boards and discharges in the training period, the vast majority of men do manage to get through the training period without becoming conspicuously maladjusted.

When the ostensibly normal person leaves civilian life to enter the Army, he has to relinquish certain modes of behavior which have been proved to be adequate for him and find new modes of behavior and new relationships which will satisfy his human needs. This requires the exchange of new love objects for old, male objects for female, regimentation for initiative, subordination for independence, group unity and purpose for individual identity and purpose and the substitution of new beliefs for old. From the point of view of a peace time democracy this life, in which normal gratifications are renounced, destructive goals are substituted for constructive goals, and new illusory devices are utilized, constitutes a strange and abnormal state of affairs. It is a new and strange life which imposes severe deprivations in exchange for fewer, different and more restricted gratifications. Hence, for most men, adjustment to it requires either a constant sense of pain and discontent, or a repression of this with exploitation of the available secondary gratifications, or both. Probably the most satisfactory and useful compensatory factor in this new adjustment is the development of group unity and loyalty. Through this means the soldier is able to fuse his personal identity with the new group identity, to form deep emotional relationships with his buddies and with his leader, in sharing boredom, hardship, sacrifice and danger with them, and whether by compromise or illusion, to become oriented with them toward the destructive goals which he understands to be necessary for the common good. This factor may be counterbalanced by the rivalries over promotion, group status, and other antagonisms inevitable when men live together intimately and share danger and deprivation.

Experience has shown that a minority group of soldiers cannot endure the training period and "break down" with protest symptoms of various kinds in the form of neurotic and psychotic syndromes of familiar types. The additional stress of the heightened requirements of the Army adjustment proved too much for what may have been an already overtaxed personality; in some instances it may have been intolerable to a personality incapable of making compromises, or of readjusting beliefs in a setting which restricts the manner in which

men may evade their fears. At any rate many soldiers drop out at this stage; still more do so when the added hazards and further separation of overseas embarkation loom, counteracted only by some expectation of novelty and adventure.

This is followed by the overseas training and waiting period in which the boredom, inactivity, suspense and unpredictability of movement prove to be difficult for many to bear and permit of fewer compensatory satisfactions than the more prosaic training period closer home. It is from this stage that the soldier emerges, usually with dramatic suddenness, into the climax of his military career, the field of combat warfare.

Before proceeding to a discussion of the latter, let us review the elements of the soldier's adaptations up to this stage. The inductee is notified, examined, accepted, classified, regimented, assigned and trained in a new, strange, and artificial society. The principal motivation appears to be his willingness to comply with the demands of his country. He masters, with varying success, boredom, resentment, disappointment, loneliness, separation, regimentation, and subordination with the various compensations of training, habit formation, new emotional bonds to his buddies and to his leader, and the development of a new group unity and loyalty. In addition he may use other psychological devices - illusions of personal invulnerability, fatalism or heroic idealism - to sustain his determination to be an effective soldier and not to go eccentric, be a quitter, or show yellow. He is sent abroad, is subjected to a repetition of his basic training, and waits "interminably", often becoming very bored and discouraged, a state of mind not helped by many suggestions that the Army is "all fouled up", has no interest in him as an individual, and uses men as cannon fodder or impersonal manpower. Suddenly he is alerted and all the old speculations are forgotten in the excitement of a great and perilous adventure; anything is better than boredom; fear is suppressed, resentment repressed and energy is concentrated upon action. He is ordered into combat.

COMBAT PERIOD

It would be misleading to assume that the situation connoted by the term "combat" is a uniform one. Group fighting in the organized fashion of modern warfare is a far cry from the individual combat between man and man, or the massed phalanx which characterized warfare of old. It is important to recognize that many of those engaged in combat do not have the opportunity of doing actual fighting; the combat situation in so far as it can be generalized is one in which many people are exposed to great danger, most of whom are serving the small groups who do the active work of destruction. Associated with this for all is the inevitable necessity of incessant waiting, sometimes because of orders, sometimes because of inescapable

shellfire and other attack from the enemy, sometimes from blocked roads or inadequate supplies. Adjustment to combat, therefore, means not only adjustment to killing, but also adjustment to danger, to frustration, to uncertainty, to noise and confusion and particularly to the wavering faith in the efficiency or success of one's comrades and command. Obviously, effective adaptation to combat presents additional problems quite different from those arising from the training period. In combat, both the disorganizing and the compensatory factors have greater intensity. The soldier faces great danger, must be able to control his fear so that he does not run from it, and has to release many of the primitive destructive tendencies which civilization and his own personal life have taught him to control. In all this, he is supported by the strength of his group, his emotional relationships to the leader and the individuals of this group, to his training in habit and obedience, and to various other psychological resources.

It was our particular concern as a commission to study the psychological phenomena involved in the failure of adjustment of the American soldier to this "combat situation". The difficulties involved in making such a study have been outlined elsewhere in this report. We do not feel adequate to portray in detail the horror of combat. We have the impression from talking to combat infantrymen, officers, and physicians, that it may be impossible to communicate to others the intensity and range of human feelings experienced. There is abundant testimony on all sides that one common emotional reaction is fear (although it should be remarked that a few exceptional individuals insisted that for one reason or another they did not experience conscious feelings of fear). Unlike the previous war the experience of fear appears to be more acceptable, although the necessity of controlling it remains. In addition to fear, however, there seem to be other emotions and reactions generally present in many, probably most, soldiers. These would include (1) the phobic-like reactions to specific types of shellfire, the 88 mm. shell and the tree burst flak or engine trouble to air crews, land mines to engineers, bazooka fire to tank crews; (2) the impotent, angry frustration and resultant anxiety from inactivity, from being pinned down by enemy fire or retreating from a superior force; (3) the fear and anxiety aroused by the mobilization and expression of the man's own aggressive tendencies; (4) the anxiety incident to distrust of the wisdom of the orders received; (5) the lack of relief and any failure to receive adequate and prompt supply of mail, food, clothing and ammunition; (6) the loneliness of foxhole fighting and the inability to communicate with his group; (7) the anger and resentment toward the behavior of comrades who let him down, or who break the code and toward those in the rear echelons who do not share his dangers and deprivations; (8) the guilt over performance (e.g. killing a young German boy) or in failure of his own performance; (9) the horror and grief (plus the revival of old, hidden and displaced hostilities) incident to seeing buddies wounded, mutilated

or killed, with whom he may have to remain for some time afterward; (10) the constant danger and the discomforts of being hungry, cold and wet, and the all pervading physical and mental exhaustion of continuous fighting.

When one considers the common denominator in the afore-stated list of emotions, one is impressed by the difficulties the soldier must have in controlling his aggressive impulses. The combat situation releases a considerable amount of hostility, much of it in forbidden directions against members of his own team. Irritability, battle dreams, and smouldering resentments precede the earliest symptoms of the breaking point and are expressions of the soldier's anxiety in realizing he is losing control over his aggressive impulses.

This accumulation of noxious factors in the soldier add up to an enormous burden. Up to a certain point external evidences of this conflict burden may not be quite apparent. Subjectively they are recognized by many, if not most, soldiers. "We all get the jitters", said one young infantry platoon leader, "especially if it lasts long enough. You get jumpy and want to dive into a hole every time you stop running or walking. You get to thinking there might be some pleasure in getting hurt - it would keep you from going nuts".

On the other hand there does seem to be a group of normal defenses against these noxious factors and an even larger and perhaps more important group of abnormal defenses. Among the former one must list (1) the significance of the group unity in which the factors of group esteem and group idealism are quite independent of personal attachments; (2) the positive personal attachments to the individuals of this group with whom he shares the dangers (3) the inner disapproval of "quitting" or being "licked" with the danger of incurring group or parental censure; (4) the assumption of confidence in leadership and command; (5) the habit of obedience and disciplined behavior resulting from his military training, particularly strengthened when there is military mastery of the tactical situation in his Army (adequate air cover, artillery support, replacement, communication and supply) and finally (6) the increased psychological and physiological vigilance and preparation for aggression stimulated by the excessive excitement and danger.

What may be more important, as we have suggested, are certain unrealistic motives and rationalizations which contribute to the soldier's defenses in mastering his fear. Among these we noted repeatedly phantasies of invulnerability, - "They won't get me". Many men actually wear amulets and many men who do not wear them fancy themselves invulnerable, protected either by God or by the Goddess Luck. Some of the more realistic phantasies are of the nature of pure gambling; the chances are against it, "I can outdraw Fate". Akin to this is the philosophy of fatalism, "If my number comes up

they will get me whether I'm here or somewhere else and if it isn't, I'm as safe here as I would be somewhere else, so what is there to worry about?" Less intelligent soldiers with defective reality testing sometimes actually underestimate the danger in spite of its obviousness and are spared considerable conflict pressure in this way. Others, for fairly familiar psychopathic reasons, welcome danger and seem unconsciously to welcome injury; some have so strong an impulse of defiance that they minimize the danger. For all soldiers the expectation of victory is a very important factor. The expectation of becoming a hero, of acquiring something for nothing - looting, liquor, sexual exploits with enemy women, undoubtedly support some. Finally might be mentioned the attitude dramatically presented to us by one sergeant who had been a very successful athlete in civilian life. For him his whole military career which had been a very colorful and dangerous one had taken on the aspect of a great game. As he said "I had the feeling all along that it was just them against us and the best team wins. If I could outsmart them or outmanouver them, that was so much for my side. If I could not I might get retired to the benches which might mean I was out for good - just the same as football." In this particular instance after many months of spectacular courage and achievement, this soldier lost the illusion that he was playing a game with an opposing team and yeilded to increasing fear and inability to carry on.

These defenses may serve to protect the harrassed soldier from any expression of his conflict beyond subjective apprehensiveness and tenseness and some objective hyperalertness or "jitters". The statistical facts indicate, however, that in a great many soldiers these defenses did not protect them sufficiently and they were sent back as psychiatric casualties to battalion aid stations. The reason for their being sent back was usually some evidence of personality disorganization.

When one considers the total pattern of defenses which are utilized by the soldier in combat, it appears that the most significant factor is the soldier's position in the constellation of his social group, the combat team. His assimilation into the group has been facilitated by various factors including the overvaluation of the group and the depreciation of other groups, the personal attachments to individuals of the group and to the leader, the security resulting from training for his specific job in the group and the assurance obtained from adequate supplies brought to his group. Belonging to the group enables him to share its successes, satisfactions, horrors, dangers, deprivations, and discomforts and in turn to be protected by its strength and to be united with it in purpose. Further confirmation of the importance of these group bonds appears in the nature of the precipitating factors of the "break".

When one reviews the details of the onset of the "break" one finds frequently that the soldier has often been able to carry on in combat for a considerable period of time, adjusting himself more or less adequately by means of his various defenses to continuous and great increments of danger and discomfort. Added to this and associated with the first signs (to the soldier) of the "break" is an event which appears to be the precipitating factor. The actual events may vary tremendously in content and in degree of severity. A battle field demotion or promotion; a friendly gesture by the enemy; the sight of a dead child; the belief, fancied or factual, that his group is lost, or captured, or killed; a sudden and unexpected change of order from command; the death of his leader - these and many more were related to us by soldiers, who after such an experience feel more distress and showed other signs of an impending "break".

Continuous combat has meant cumulative stress. Paramount in this stress are the effects of fatigue and hunger, of fear relative to incessant danger, and a series of repeated narrow escapes, following one another in rapid succession. With no adequate recuperative pauses between the repetitive experiences, one's compensatory mechanisms are tried to the limit, especially when fatigue and lack of sleep are coincident. A pattern of adjustment has been maintained marginally, one unequal to a sudden increment or a qualitative change in the situation. There is left little or no reserve, other than to revert to a less organized, less dangerous pattern at a lower level of human functioning.

The crucial factor concerns the pattern of the soldier's group relationship. The common denominator of the events experienced by the soldiers and related by them as precipitating factors were less frequently the "last straw" in a quantitative sense than some event which necessitated a sudden change in the basic structure of the pattern of the soldier's group relationship. He had been able to carry on with his pattern. The precipitating event shattered this pattern. The soldier lost his group relationship and in losing it forfeited all the strengths and comforts with which it had sustained him. As a member of the team he would have been able to take it; alone, he was overwhelmed and became disorganized.

It is a very obvious fact that the psychiatrically disabled soldier cannot function well in the close-knit combat unit, but this is not our point of emphasis. Here we mean to emphasize the fact that the organized pattern of the unit and its emotional bonds constitute the dominant constructive and integrative force for the individual soldier in his fighting function. This group life <u>is</u> his inner life. When an individual member of such a combat group has his emotional bonds of group integration seriously disrupted, then he, <u>as a person</u>, is thereby disorganized. The disruption of group unity is, in the main, a primary causal factor, not a secondary effect, of personality disorganization.

We find that American psychiatrists and other physicians have considerable difficulty in grasping the significance of the group as the core of personality organization for the soldier in his fighting function.

Our modes of psychiatric thought and practice and our general American ideology have been almost exclusively developed on the consideration of the individual - his ontogenetic personal development as an individual and his individualistic experience. This point of view has not actually been adequate for the best civilian psychiatric practice, but its inadequacy has been generally overlooked, in part because of the professional difficulty in grasping and utilizing new concepts. It is our impression that a psychiatrist adhering to the exclusively individualistic point of view in psychiatry is quite unable to understand a large proportion of the psychiatric disabilities of the combat soldier, because he lacks insight into the vital function of the group in the life of the individual, - a factor which becomes of major and crucial importance for most soldiers in combat functioning.

It appeared to us that the precipitating event might disturb the pattern in two - not necessarily alternative-ways. One was the altering of the structure of the group, with subsequent effect on the individual; the other was in affecting the individual directly and subsequently his relationship to the group. Furthermore, the precipitating event may have a double meaning. For reasons of a more individual and personal character the event may have evoked certain old, buried and displaced emotions. For example, (1) the tactical error of the commanding officer may lead to the expression of exaggerated hostility and distrust related originally to unresolved feelings of rebellion toward a father; (2) ambivalent conflicts may arise in connection with the death of a comrade so that the soldier experiences simultaneous grief and guilt ("I'm glad it was him, not me".) where the source of the ambivalence is rooted in a sibling rivalry of an early life period; (3) a failure of performance may not only lead to thoughts of losing "face" and the esteem of the group in the current scene, but touch off inner unresolved feelings of inadequacy in one who has found it necessary always to achieve success in order to deny his feelings of inadequacy; (4) the experience of a wound, or the sight of a mutilated comrade, may not only mobilize realistic anxiety but may light up hidden, distorted, and anxiety-laden concepts of mutilation or castration; (5) friendly gestures from the enemy may lead to increasing confusion as to motivations for fighting, for in protracted combat the soldier's relationship to the enemy may be characterized by a feeling of kinship with him, as his group and the enemy seem to be the only people who are sharing equally the hardships and the horror of warfare.

The statistical evidence is very clear that the precipitating events are closely associated with the intensity of combat. Roughly speaking, for every five men wounded, one is killed and one becomes psychiatrically disabled.

When the precipitating event is added to the saturated adaptation, the soldier finds it impossible to continue to be an effective member of a combat team. He may become so completely disorganized and so obviously militarily ineffective that he is brought to the battalion aid station. Some are not so thoroughly disorganized, but, unable to function as the situation demands, may find escape from that situation through conscious or unconscious means, at a lower level of functioning.

A small number consciously seek relief from the conflict through voluntary surrender or desertion. A few are disabled by self-inflicted wounds or "accidents". The motivations for these appear to be partly conscious and partly unconscious. The wound, even though self-inflicted, is part payment for escape from an intolerable situation and thus serves to maintain an altered type of psychic equilibrium.

The greatest number reject the previous two solutions. These are prohibited techniques, which offend group loyalty, personal idealism and military law. But there is little left, -- one can only be killed, captured or wounded. The conscious and unconscious wish for a wound assumes special significance. By being wounded he will obtain relief without losing prestige or glory; in fact, he may gain both through the experience. But the wish for a wound engenders conflict, as it has ambivalent value. The wound will hurt, it may blind or castrate him, or it may even kill him. Consciously he is in a state of ambivalent expectation of a wound, or alternatively of "blowing his top", and in the setting where his buddies are being wounded he is impelled, through unconscious mechanisms of identification with his wounded buddies, to act as if he were wounded.

The less sophisticated, or less intelligent soldiers may be able to achieve this unconsciously by the development of hysterical conversion symptoms, blindness, deafness, paralysis, or amnesia, which are probably equated with wounds and which enable him to go to, or be brought to, the battalion aid station. More intelligent and sophisticated soldiers are apt to come to the aid station complaining of a loss or inadequacy of mental functioning: "I can't take it any more - I just can't carry on!" Here, too, although the psychological symptoms are more subtle, they are probably equated with wounds. Through these unconscious mechanisms the soldier solves his conflict and escapes honorably from the intolerable combat situation through experiencing psychic wounds. Through these psychic wounds he is reduced to lower levels of human functioning. Infantile behavior or forms of previous neurotic patterns may be observed in which he is

able to achieve goals of escape, safety, and the reassuring comfort of the therapeutic situation.

It is difficult for us to formulate clearly any or all of the determinants of the relative vulnerability of combat soldiers conducive to these developments. We heard from many that "constitutional differences" were significant determinants. We know of no body of data nor any method which allows one to distinguish behavior alleged to be due to certain inherited predispositions from behavior said to result from the effects of certain early life experiences. Theoretically, one would assume that the ostensibly normal person who is able to make and maintain friendly relationships, one who has good home ties, one who is able to tolerate a reasonable amount of pain, danger and deprivation, and one who is able to adjust equably to roles of dependence and responsibility would have a more or less normal degree of vulnerability,-- assuming few, if any, to be completely invulnerable. We have learned, also, that there are many who are able to utilize successfully for various periods of time certain abnormal psychological devices.

Finally there are others who appear to be highly vulnerable and in whom one may find later, in the anamnestic study, that there have existed excessive needs for dependence and many evidences of unresolved emotional tensions which are displaced to the scene and characters of the combat stage, resulting in a much smaller capacity to tolerate the effects of the noxious forces. It may be fair to state that in our opinion present methods of personality scrutiny at induction do serve an important function in screening grossly and eliminating those unfit for military service because of severe intellectual and emotional limitations and defects. On the other hand, we know of no method which enables one in a majority of instances to determine who will be the most effective fighters. The matter of previous personality structure appears to us to be, together with the combat situation, an important determinant of the form of the "break" when it occurs. As will be discussed in the following section, a great number of soldiers who are designated "combat exhaustion" experience such an overwhelming disorganization of the cohesive forces of the personality that it is difficult to fit it into our previous civilian concepts of abnormal human behavior. On the other hand, there are others whose behavior appears to be more organized, the personality appears less shattered, the adaptive processes or symptoms more similar to those which one finds in civilian life.

In a final consideration of the many social, military and psychologic forces which interplay in the preparation and the performance of the American combat soldier, we wish to emphasize again that the most significant constructive forces are those which relate to the cohesive social strength afforded him by his membership in a team and his loyalty to his leader. This knowledge of the

significant interdependence of mankind has never been stated more eloquently, or more succinctly, than by John Donne, the English poet, in 1624.

> "NO MAN IS AN ILAND, INTIRE OF IT SELFE ....
> ANY MANS DEATH DIMINISHES ME, BECAUSE I AM INVOLVED IN MANKINDE: AND THEREFORE NEVER SEND TO KNOW FOR WHOM THE BELL TOLLS;
>
> IT TOLLS FOR THEE."

The members of this commission regret that we had little opportunity to investigate the deeply unconscious forces concerned in the psychodynamics of combat exhaustion and in the constructive and destructive aspects of military group structure. We have not wished to complicate this discussion by the insertion of theoretical constructions based on preformed opinions. The omission of a more detailed consideration of these deeper unconscious forces does not represent any feeling that they are unimportant, but merely reflects our inability to get the clinical material necessary for an adequate study.

EVOLUTION OF THE CLINICAL PICTURE OF COMBAT EXHAUSTION AND THE SEQUELAE

In the previous section we have tried to indicate how the combat soldier, exposed to internal and external stresses, may suddenly deviate from accepted channels or patterns of behavior in such a way as to render him unfit for duty, so that he becomes a casualty. In trying to present an adequate clinical picture of combat exhaustion it is necessary to begin with the first evidences of an incipient failure in the maintenance of psychological equilibrium.

INCIPIENT STAGE

There is almost unanimous agreement that the first symptoms of this failure are increasing irritability, and disturbances of sleep.

The irritability is manifested externally by snappishness, over-reaction to minor irritations, angry reactions to innocuous questions or incidents, flare-ups with profanity and even tears at relatively slight frustrations. The degree of these reactions may vary from angry looks or a few sharp words to acts of violence.

Subjectively, the state of irritation is perceived by the soldier as an unpleasant "hypersensitiveness" and he is made doubly uncomfortable by a concomitant awareness of his diminishing self-control. One patient put this vividly by saying - "The first thing that brought home to me the fact that I was slipping was this incident: A fellow next to me took some cellophane off of a piece of hard candy and

crumpled it up, and that crackling noise sounded like a forest fire. It made me so mad I wanted to hit him. Then I was ashamed of being so jumpy".

In association with this "hypersensitiveness" to minor external stimuli, the "startle reaction" becomes manifest (increasingly so as time goes on). This is a sudden leaping, jumping, cringing, jerking or other form of involuntary self-protective motor response to sudden, not necessarily very loud, noises, and sometimes also to sudden movement or sudden light.

The disturbances of sleep, which almost always accompany the symptom of increased irritability, consist mainly in the frustrating experience of not being able to fall asleep even upon those occasions when the military situation would permit. Soldiers have to snatch their rest when they can. They expect a rude and sudden awakening at any time. Opportunities for sleep become very precious and an inability to use them very distressing. Difficulties were experienced also in staying asleep because of sudden involuntary starting or leaping up, or because of terror dreams, battle dreams, and nightmares of other kinds.

This triad of increased "sensitivity", irritable reactions, and sleep disturbances represents the incipient stage of "combat exhaustion". It usually does not lead to referral. It may exist without much change for days, weeks and even months. Sooner or later, often upon the occasion of some incident of particularly traumatic significance to the soldier, the marginal and very unstable equilibrium is upset and the soldier becomes a casualty.

STAGE OF PARTIAL DISORGANIZATION

These disabling disturbances in adaptation are shown externally in alterations of behaviour or attitude which attract the attention of comrades, officers, or medics, and lead to the soldier's being conducted or directed back to the battalion aid station. There seems to have been a considerable variety of these behaviour disturbances, occurring in various combinations. The following typical manifestations appear to have been the most common, but not necessarily in this order, either of frequency or of sequence.

1. General psycho-motor retardation, with difficulty and slowness in doing familiar everyday acts, in recollection, in concentration, and in responsiveness to orders.

2. A tendency to become seclusive, morose and silent, or the reverse, i.e., to talk excessively, smoke excessively, sometimes, when possible, to drink excessively.

3. A tendency to discard belongings with the complaint that everything is too heavy, too much to bear, etc. Such men often throw away valuable and much needed personal belongings, military equipment, and even food.

4. An apparent "affective flattening" with a loss of interest in comrades, military activity, even food and letters from home. Food may go uneaten, letters unread.

5. An increased apprehensiveness and ill-concealed fearfulness.

6. An increasing dependence upon comrades and others, with unwonted reluctance to accept responsibility or to exert initiative.

7. A tendency to be confused, even to the point of slight disorientation, with impaired judgement, uncertainty of movement and the like.

8. Various somatic symptoms such as tremor, vomiting and diarrhea.

This list represents the symptoms of personality disorganization which lead to the referral of these patients to the battalion aid station. They occur in spite of variable degrees of effort on the part of the soldier to control his behaviour, stifle his conflict, and suppress his rising fear and anxiety with fierce determination to carry on. Sometimes this determination is very great, and leads the soldier to conceal his disability. Some soldiers, if they complain at all, complain only of such obvious matters as fatigue, inability to sleep, lack of cigarettes, or the incessant pounding of the artillery.

This condition is well known to most soldiers, certainly to all medics and to all NCO's in the battle zone. It is well known also to command officers; their attitude toward it will be discussed elsewhere in this report. In most instances, such disabled soldiers are sent or taken back to the battalion aid station; occasionally they come of their own accord. Sometimes they are not sent back because they conceal their symptoms, and at other times they are not sent back because they cannot be spared, handicapped though they are. In still other circumstances, they are not sent back because of failure on the part of their officers to recognize their condition, or failure to appreciate its nature.

STAGE OF COMPLETE DISORGANIZATION

If such patients are not sent back, the next stage either follows spontaneously or is precipitated by additional stress. Any or all of the above symptoms may suddenly become much worse. The soldier may become unstable, erratic, obviously confused, savagely irritable, quite unreasonable, and even defiant and recalcitrant. He may clamber out of his foxhole in the face of danger or freeze to it when danger has passed or when it is safer to go elsewhere. He may run aimlessly

about, exposing himself perilously; he may stand mute, staring into space; he may go to his CO pleading that he is not fit to command his detachment. He may break into uncontrollable sobbing or screaming. His speech may become jerky, stammering and incoherent. He may babble like a baby or make smacking or sucking movements of the lips. There is apt to be some tremulousness, especially of the hands and head, physical movements become awkward and incoordinate. Nausea and vomiting are very frequent.

These indications of full-blown demoralization are, of course, practically always sufficient to effect referral to the battalion aid station.

BATTALION AID STATION SYNDROMES:

Patients are seen in battalion aid stations in all three of the conditions described above as incipient, partial and complete disorganization. It is helpful for the purpose of discussion to divide these patients into two groups, those who come to the battalion surgeon very early in their comb t experience and those who come to him after long experience in the combat zone, although these groups are not sharply differentiated by clinical symptomatology.

It was the general concensus that waves of psychiatric casualties came to the battalion aid station after the first baptism of fire. Presumably such initial experiences acted as a screening process which served to precipitate out of the line those of lesser stability or whose greater conflictual tension had brought their adjustment to a marginal level. For others the baptism of fire seemed to act in the direction of preventive innoculation.

The early psychiatric casualty may arrive at the aid station after a day or a week of combat in a moderate degree of disorganization. He is jittery, tremulous, restless, jumpy, obviously frightened or "fright burned". The irritability described as so typical in the field may be diminished with the transfer to the medical station and its relative safety, but sometimes it is increased. One psychiatrist described a typical soldier in this state as, "a very weary, dirty and dishevelled man sitting with his head in his hands, trembling and jerking, muttering over and over, "Shells and tanks, shells and tanks", or "It was the 88s, Doc, the 88s all the time", or "I can't stop shaking". This picture was by far the most common, comprising as we were told from 80-90 percent of the psychiatric cases seen by the battalion surgeon.

A smaller number of patients arrive in the more demoralized state of complete disorganization; they are brought to the battalion aid station strapped to a litter, fighting, struggling, screaming and yelling. They attempt to dig in the ground or to leap under a bed. They may seem to respond to hallucinations and they may show some degree of disorientation. Still others demonstrate equal demoralization by standing about mute, trembling, fumbling, staring into space and making no response to interrogation. A few patients at this stage show classical hysterical (conversion) syndromes with such symptoms as amnesia, aphonia, amaurosis, deafness, paralysis, anesthesia and convulsions.

The experienced soldier may have been hardened and toughened by a succession of combat experiences, so that the terrifying sights and scenes of the battlefield no longer have the fresh impact of novelty. The protective armour of fantasy, rationalizations and philosophy, and above all the self-confidence of experience and the intensified group identification may have strengthened him. But his resistance has been subjected, on the other hand, to assaults from two new quarters. The more powerful of these is undoubtedly the experience of losing comrades. In the opinion of many observers, this is the most destructive influence bearing upon personality integrity in the battle situation. The maintenance of the psychic equilibrium, the defense against yielding to fear and chucking the whole business has its chief emotional anchorage in personal attachments, and unit identification. The loss of a comrade, of a respected commanding officer, or of a member of the squad which he - the soldier under consideration - has been leading may constitute a wound more painful than that of a bullet through the body. Grief, in short, is for the veteran, added to fear, fatigue, discouragement and all the pre-existing burdens. In part it is neutralized in some individuals by the incitement of impulses for revenge.

In addition to the grief over lost comrades, however, there is often the added factor of resentment regarding the lack of replacements, or the clumsiness and unpreparedness of particular replacements. Such resentments may be heightened by the interminability of the fighting and the lack of clear objectives or of information about the mission. Anxiety referable to cumulative distrust of command thus contributed to this.

At any rate, grief, accumulated fatigue, and resentments (offset to some extent by reinforced fighting motivation) are now added factors which may precipitate a psychiatric disability in the veteran.

Just how do these veteran cases as they are seen in the battalion aid station differ from the previously described cases seen there?

It is our impression that if they can be distinguished at all by clinical symptoms from the more general syndrome of disorganization above described in the "green" soldiers, it is on the basis of less excitement, less panic, less extreme demoralization, and more evidences of depression. Numerous cases seen by us in forward and again in rear installations had definite depressive elements in their symptomatology. The depression may be masked and controlled, indicated only by facial expression, slight retardation, an air of weary resignation and complaints of inadequacy. Such patients frequently say, "I just wasn't up to it. It got too much for me. I just couldn't take it. I wasn't any good any more". etc.

Depression is more evident in those patients who relate their chief conscious distress directly to the loss of comrades, or to a line failure in performance or to failing powers of self-mastery. This picture is so common in certain types of older individuals, especially longtime Army non-coms with concern about the loss of soldiers trained by them, that it has been designated in several places "the old sergeant's syndrome". It occurs, of course, in other than sergeants and other than old Army men.

It should be repeated that this depressive coloring of the syndrome does not predominate in the majority of cases or in the "typical" case of combat exhaustion. Most of these men who have been in combat for as long as 10, 12 and even 15 months, once they break down, very much resemble the picture described above for the green soldier in his first combat. There is the same heightened irritability, the same disturbance of sleep, the same complaint of ineptness, of great difficulty in accomplishment of things that were formerly easy to do, an increasing discomfort from sensations of fear and uncertainty, confusion, etc. These patients, like the others, come to the battalion aid station obviously weary, tense, tremulous, uninterested in food, unable to sleep. They have been described by one division psychiatrist as "the war weary", by another as "combat saturated". Questioned, they have rather little to say: "I guess I'm through. I couldn't function any more. It finally got me, the noise and all. Never used to bother me, but I have been slipping for a month." (Although we shall discuss treatment elsewhere it ought to be remarked here that these veteran patients do not respond favorably to brief rest periods or sedative treatment. As one division psychiatrist put it, "They're right when they say that they're through - they are through, for good.")

One of the veteran cases we saw was the eldest son of a widow, whom he had supported along with his younger brothers and sisters. He paid for his siblings' education, although obtaining none himself.

He had been a YMCA athletic director, a Boy Scout Troop leader, a man of high ideals whose recreation in civilian life was to take groups of boys out on camping trips. His ideal was his mother "who never raised her voice in all her life". He had had 32 months of service overseas as a platoon leader in some of the most violent engagements. Upon one occasion a mine explosion killed every one in his car except himself. He had been given a Presidential Citation, Bronze Star, Silver Star, Purple Heart and one cluster. The whole business of fighting had gone against the grain for him from the start; "I never killed anything - never believed in it - couldn't kill a cat. When I first had to kill a German I dreamed about it and worried about it for a week. Now I try not to think of it - I have had to kill so many. But now I can't do it any more."

Another patient we saw had had fifteen months of combat in Africa, Sicily, France, Belgium and Germany. His chief job was to destroy mines and booby traps. Only after this long period of service did he "crack up" (with the same symptoms as a green soldier - jitters, tremors, careless exposure, aimless running around, sleeplessness, and so on). His guiding principle, he said, was his mother. "She told me to always do the right thing in the Army and so I do." His postwar ambition was to be a male nurse!

These cases are cited to indicate that sensitive individuals may escape early demoralization, pursue heroic fighting careers only to crack up ultimately in forms very much like those of the green soldier.

The question arises as to whether it is possible to indicate a maximum number of days of continuous fighting or a total number of days of intermittent fighting which even the sturdiest and most stable soldier cannot endure. One of our informants had concluded from his observations that 180 days is such a maximum figure, that to expose a soldier who escapes injury or death to more than this amount of combat is to sacrifice manpower uselessly.

GENERAL DISCUSSION OF PSYCHIATRIC SYNDROMES SEEN AT THE BATTALION AID STATION

For purposes of clarity in the outline of the clinical picture, we have tried to separate the acute combat cases into groups above described. It should be emphasized, however, that while there are tendencies in the direction of slightly different symptom constellations as mentioned, there is no clear, clinical demarcation so far as we could learn, nor are the patients classified by the battalion aid surgeon on any such basis. In many instances the battalion

surgeon probably had no idea and no time to ascertain what length of service his patients had seen. What he saw, in addition to all the surgical cases which poured through his hands, was a number of unwounded men who had been sent back because they couldn't fight any more. Most of them were jittery, tense, sleepless, excited, irritable, sleep-desiring but sleep-deprived, physically weary soldiers. Various battalion aid surgeons interviewed estimated the proportion of psychiatric cases as from 1/2 to 1/5 of all seen.

It was the conclusion of the Commission, and also of practically all the psychiatrists who were interviewed, that this picture of psychological disorganization does not correspond either in its moderate or in its extreme form to any recognized or established psychiatric syndrome. It has elements of excitement, of inhibition, of terror, of panic, of depression, of anxiety and of dissociation. It certainly is not merely a state of "exhaustion". It certainly is not a neurosis in the ordinary sense. It certainly cannot be adequately described as anxiety or fear. Such terms, therefore, as anxiety state, exhaustion state, operational fatigue, and so forth are not accurately descriptive. It comes closer to a "situation psychosis" than anything else, but its subsequent clinical course is quite different from the recognized situation psychosis of civilian life. We shall deal later in this report with the question of nomenclature and we shall conclude the present discussion with a repetition of our belief that the syndromes observed at the battalion aid station represent for the most part a temporary psychological disorganization out of which, under circumstances to be described, various more definite and more familiar syndromes evolve.

METAMORPHOSES OF THE SYNDROME

Our effort has been to portray the picture of disintegration in a soldier up to the time that he arrives at the battalion aid station. Here several important things take place which have a definite effect upon the subsequent evolution of the syndrome.

In the first place the patient has usually been ordered out of the combat line or taken out of it by some responsible person. This breaks his connection with the unit, but it also removes him from the field of greatest danger.

The breakup in psychic organization is concomitantly a breakup of morale, of self-mastery, and of unit membership. The soldier thus affected is in the hands of the battalion aid surgeon to whom

he is taken or to whom he goes spontaneously.

In this new situation there is a radical change in the direction of pressures. From being an active, aggressive fighter, he has become a passive, ineffective "patient". He has surrendered membership in a unit of comrades for a lonely, though physically safer, retreat. He is given some food, an opportunity to sleep, a few words of reassurance, sometimes exhortation, by a doctor. He may be impressed by the inflow of seriously wounded comrades with whom he can compare his own disability.

Twenty-four hours later some of these patients, who were jittery, jumpy, jerky, panicky, and generally demoralized, are able to shoulder their packs and trudge back to the front lines in a fair degree of composure, ready to reunite themselves with the group, assume their responsibilities, and continue on in the same situation of stress and danger as before. It is amazing that some do this; it is still more amazing that so many do so. Just how many do it we do not know. We were told by some that 95% of these patients went back to duty within 48 hours, and were told by others that less than 3% of them did so.

In the manual of therapy for the ETO issued 5 May 1944 it is stated (page 129) that the majority of these battalion aid station casualties do not go back to the front lines, but "have to be sent to the evacuation hospital". This manual, of course, was issued before D-Day and was presumably based on experiences in the African, Sicilian and Italian beachheads. Colonel L. J. Thompson voiced the opinion that 40% might represent a fair guess as to the proportion immediately returned. There is a good deal of variation in the attitudes and opinions of the battalion surgeons; some felt that while many of these patients could be sent back to active duty it would only be a few hours or days until they were once more in the battalion aid station, a process which if it had been continued might theoretically result in the statistical absurdity familiar to all psychiatric statisticians of obtaining a paper recovery rate of 110%! It is very hard even to estimate what the facts are in this matter, and they probably varied enormously according to the tactical situation. Undoubtedly some battalion aid surgeons sent back to the front line soldiers who were unable to stay there, and others failed to return to active duty some who could probably have succeeded. It is not surprising that errors of this type were made; it would be more surprising if many such errors were not made.

The fact that so many soldiers could be restored within such a short length of time with such a minimum of treatment facilities

seemed to us to point on the one hand to the toughness of the American soldier (in contradiction to contrary estimates voiced to the Commission by even some high ranking medical officers) and on the other hand to the importance and effectiveness of the work of the battalion surgeons. It was agreed by all those interviewed that the personality, attitude, judgement and technique of the battalion aid surgeon were of the highest importance and that for the maintenance of manpower in the Army no other medical officer contributed nearly so much. Credit should also be given to the medics, line officers and non-coms, who, as a result of training, experience and sensitive alertness, recognized these cases for what they were and recognized them early enough to get them back to the battalion aid stations, where this prompt rehabilitation could be effected.

So much for one type of outcome or metamorphosis in the picture of acute combat exhaustion. We must next consider the fact that many patients because they were more completely or intractably disorganized, because they came to the battalion aid station too late, because their conflicts were of a different order, or because their powers of resuscitation were less, or for some other reason, did not make this prompt recovery. They did not impress the battalion aid surgeon as having recovered or as likely to recover after a few hours or even a day or two of rest, and were sent back to clearing stations. Here they were kept not more than 2 days usually before being returned to duty or sent still further back to the exhaustion center or evacuation hospital, where they stayed from 5 to 8 days.

CLEARING STATION STAGE

The acute state of complete disorganization seems to tend to change rapidly, at least in many cases. The cases received at clearing stations are less frequently demoralized to the extent described above and more frequently apathetic, listless, tense, restless, apprehensive, mildly confused, jumping at every sound, sweating excessively, unable to read, write or sleep.

Again, some of these patients improve remarkably after 2 or 3 days of rest, sedation, sleep, warm food, and sometimes reassurance and counsel by the physician.

Those who do not respond go further back, then, to the Exhaustion Center. By this time - from 1 to 4 days out of combat - there begin to be further new clinical features.

EXHAUSTION CENTER STAGE

The chief of these is an increasing depression, with self-depreciation and sense of loss and guilt. This is related to reflection, upon the separation of the soldier from his unit, his friends, his familiar patterns of behavior, his feeling of shame for having been unable to "stick it out" and for having achieved a place of safety while his comrades remain in combat. Although usually not talkative, he will often confess his preoccupation with numerous fears - the fear that he is incurable, that he is going crazy, that he is unable to do anything, that he will be blamed for cowardice, etc. He is not relieved by reassurance, even the suggestion that he may be sent home. He may complain of heartburn, diarrhea, polyuria, and the feeling that he is about to faint. In the clinical evolution some of the familiar psychiatric "entities" of standard types become distinguishable - crystallize out or split off so to speak - from the main group.

At this stage it is possible to identify a depressed group, a hysterical group, a schizophrenic group, a psychosomatic group, a hypomanic group, a "psychopathic personality" group. But the majority of patients continue to represent a vague, amorphous, anxiety-laden syndrome similar to that seen in the battalion aid station.

Again, at this level, given appropriate treatment of the type to be described elsewhere, a large but variable per cent of the main group recover sufficiently within ten days to be returned to combat or to limited duty. The rest are referred on back.

GENERAL HOSPITAL STAGE

Those patients who do not recover within ten days at the exhaustion center reach general hospitals or special psychiatric hospitals, usually within fifteen to twenty days after their withdrawal from combat. Upon admission there these patients are still jittery, tense, highly irritable, and sensitive, sleeping poorly and complaining also of numerous somatic symptoms, exhibiting a weight loss of ten pounds or more, cooperating poorly. The depressive symptom may be, and often is, replaced by resentment and a hostile attitude toward the Army, sometimes toward everyone connected with the Army, even fellow patients. (This aggressiveness may sometimes be an indication of progress toward recovery.)

Again there is the splitting off or the recognizable development of a small percentage of definite depressions, schizophrenics,

hysterics, etc. But we were told that a large percentage of the patients who are properly and promptly treated recover sufficiently to return to some line of duty at this level after a treatment regime of thirty days.

Among patients at the general hospitals there are many who show a puzzling vagueness in symptomatology. Several whom we saw had headaches, one had a ringing in his ears, one had pains in his legs, one pains in his stomach, several were mildly depressed, and all felt incompetent to return to duty. Sometimes we had the impression of the emergence of rather definite "neurasthenic syndromes" - mild depression, slight querulousness, plaintiveness and complaintiveness, obvious discomfort, slight anxiety, and a general lack of zest for life, and so on. By the time we saw them these patients had been hospitalized for one to two months and had had a good deal of treatment of various kinds; some had developed the invalid attitude and no longer faced the problem of being returned to active duty in the ETO. There were others preoccupied, like all other ETO personnel, with the uncertain but likely prospect of going to the CBI Theater.

To indicate how psychological testing might be expected to yield a somewhat different concept regarding these cases, the following illustration is submitted:

A patient was seen by one member of the Commission at a general hospital on 25 May 1945, who after two months of combat had developed rather typical combat exhaustion, and had then gone down the line from hospital to hospital over a period of three months. After a certain amount of treatment he had been regarded as capable of being returned to limited duty, at which he had continued for two weeks only. He had returned to the hospital with marked restlessness, tearfulness, disturbed sleep, battle dreams, fantasies of suicide and so on. A Rorschach test was made on this patient by the hospital psychologist, and the interpretation given that he was "without clinically manifest neurosis but was self-conscious, rigid and introverted." This Rorschach test protocol was submitted by us to a clinical psychologist of large experience who gave the following report: "In civilian practice the patient represented by this test would have been regarded as suffering from anxiety hysteria, with intense anxiety partly free floating and partly bound, and with phobic features....Bodily preoccupations and an ego weakening in the direction of psychosis. Details of the record are present which appear to refer to maladjustment existing previous to battle experience by the latter. These pre-existing symptoms are possibly not of a type or severity which would have led to his rejection at the time of induction."

A few words might be said regarding certain special pictures. The so-called "blast syndrome", for example, seemed to the Commission to bear a very close relationship to the main "combat exhaustion" syndrome here traced with a certain difference in the type of precipitation, the occurrence of unconsciousness and the additional symptom of localized amnesia.

A more important, certainly more frequently seen, syndrome is one for which a British "Tommy" slang term has been widely adopted and might be applied here - "browned off". To be "browned off" is to be thoroughly fed up and disgusted with all things in general and many things in particular. In patients this is usually accompanied by outspoken resentment toward the Army in general, and officers in particular, (medical officers sometimes not excepted). One patient we saw, for example, talked with us freely only because he was told that we were civilians. He said he had been lied to, "kicked around", mistreated, given promises which had been broken, etc., ever since he had been in the Army. He said, "My Mother is the only friend I ever had, I should have listened to her and not joined this ---- Army, and be ordered around by these ---- officers, who do not give a ---- for me nor for anyone else."

These cases often show a quasi-paranoid attitude, without it being possible to say that they are definitely delusional. Their accusations are often apparently based on fact. It is not so much the accusations themselves as the enormous emotional content characterizing them, the bitterness, the loss of trust or confidence in any human being connected with the Army, which constitute their psychopathological nature. (See section on Classification and Nomenclature.)

Two other conditions should be referred to. The rapid transfer from one hospital to another causes some patients a good deal of apprehensiveness, frustration, confusion, disappointment, and resentment, as mentioned above. One patient we saw had been in twelve hospitals before he reached the one in which treatment was administered. Another patient claimed to have been in fifteen installations. We saw several who had been in six or eight. We were tempted to call this "hospital exhaustion". What it amounts to clinically is an exacerbation of the symptoms, with strong tendency in the direction of chronicity.

The same thing, to an even greater extent, applies to what the Commission called "repple-depple exhaustion", the anxiety, frustration and depression incident to being sent from a hospital to a reassignment depot, there to wait day after day for an assignment which

might or might not correspond to medical recommendations, but which would certainly not return the soldier to his original outfit.

It is estimated that perhaps half of the psychiatric patients go back to combat duty from the battalion aid station. Those who return to duty directly from this station are not officially recorded as neuropsychiatric casualties. Of the other half (those evacuated toward the rear) approximately 50-60% are returned to duty from clearing station or exhaustion center. The residual (20% or 25% of the original group)come to psychiatric treatment in general hospitals or in special psychiatric hospitals in the Zone of Communications. The percentage returned to duty is higher from the special psychiatric hospitals (about 80%) than from the general hospitals (about 30%). The residue, amounting perhaps to 5% of the original "combat exhaustion" cases, fail to return to any duty in the Theater within 60 days of the original "break". Whatever the exact figures may prove to be, if they can ever be proved at all, it is certainly true that the vast majority of the acute states of "combat exhaustion" do return to duty of some kind, for some length of time. The residual syndromes, as observed in the Zone of the Interior, are seen in that 5% portion which responds least well to treatment.

SUMMARY

An acute climactic psychological disorganization may be precipitated in a soldier subjected in combat to a series of mounting stresses and conflicts. Most of those showing this picture tend to make a rapid recovery under various treatments in various types of installations. Among the remainder there is an increasing differentiation of various smaller clinical groups corresponding to recognized syndromes, and a small proportion of the original cases assume chronic residual forms of various types.

CLASSIFICATION AND NOMENCLATURE

This Commission has been asked to formulate some opinion about nomenclature, especially the term "combat exhaustion", which has been extensively used in the E.T.O.

It is easy to criticize this term. The word "exhaustion" puts the emphasis upon only one aspect of a complex situation and a complex reaction - a reaction which involves emotions and attitudes to a much greater extent than the word exhaustion usually connotes. The term implies also that the physical exertion incident to combat activity is the crucial point, whereas the fact is that these disabilities occur most commonly when troops are pinned down and unable to do much. From the histories of those who have endured long and

intensive combat experience in some campaigns and have become acute psychiatric casualties in a later campaign, it appears that specific incidents of combat may have more pertinence than does mere prolonged stress. Indeed, as we know from experience in the Zone of the Interior, there may develop in some soldiers, aviators and sailors a tense, irritable and "jumpy" condition, clinically equivalent to certain forms of "combat exhaustion", not in direct time relation to fatiguing combat service but only on returning to duty after furlough at home.

In respect to the objection that "combat exhaustion" is not a proper diagnostic term because it shades off into the region of normal fatigue, it can be said that this fact is at times a practical advantage, enabling the doctor to deal with a quibbling soldier or officer by saying; "Why, yes, Pvt. Smith has some combat exhaustion, but he is not disabled", or "Well, no, Corporal Jones isn't completely exhausted, but a few hours rest right now may save a good man for the unit".

The fact that the term "combat exhaustion" may be interpreted in a limited physiological sense may bring both advantages and disadvantages. It carries the helpful, and often justified, implication of possible prompt recovery with relatively simple first aid treatment; yet the crude simplicity of the interpretation may lead to neglect of important psychological principles in treatment and prevention. The term in its physiological connotations may influence some patients toward hypochondriacal or neurasthenic attitudes, as did "shell shock".

Yet there is a large group for which the term "combat exhaustion" seems justified from a consideration of the conditions under which it most typically occurs. The statistical fluctuations of incidence in relation to conditions of combat indicate that these conditions outweigh individualistic factors in determining the onset of such disabilities. There are numerous prompt recoveries with rest, sleep, hot food, and a brief period of comparative security.

Since the term is justified as a sort of "first aid diagnosis" for a large group, then under the circumstances of battalion aid station and clearing station, where sharp differential diagnosis is difficult and relatively unimportant, the term may justifiably serve as a common denominator to indicate tentatively all sorts of psychiatric conditions until a more definitive diagnosis can be reliably made.

At the level of the general hospital and the special psychiatric hospital there are trained psychiatrists with diagnostic facilities and time to make more discriminating differential diagnoses. At that level under current practices, it is also true that the cases differ considerably from the cases seen at battalion aid stations. A large proportion of the patients, particularly those for whom the term combat exhaustion is most apt, do not reach these hospitals because they are returned to duty from a more advanced station. The residue have also undergone some clinical evolution. Therefore most of them here show more definitely crystallized patterns of the commonly recognized neurotic or psychotic illnesses. At that level the term "combat exhaustion" loses its principal practical advantages as a diagnostic label, although remaining clinically significant as indicating a precipitating factor.

We believe that "combat exhaustion" should not be used as a definitive diagnosis on patients transferred from these hospitals to the Zone of the Interior, for to use it so would weaken or destroy its practical value as a temporary label and reduce to an absurdity some of its most useful connotations. At just what point along the line of evacuation, prior to this point, the term "combat exhaustion" should be replaced in the individual case record by a more definitive term will depend upon two considerations: first, how definitely the individual patient shows some clearly recognizable clinical syndrome: and, second, how slowly or how quickly he passes along the chain of evacuation. These are variable conditions, and the latter is likely to be even more variable in the Pacific theater than it has been in the European theater. We consider it reasonable therefore to permit the use of the label "combat exhaustion" in certain cases up to and into the general hospital or psychiatric hospital in the Zone of Communications but not beyond that level.

When the persisting disability comes to the stage requiring definitive diagnosis, a very large proportion are labeled "anxiety state", with a fair degree of justification; but this becomes a very heterogeneous group. Our observations lead us to comment tentatively upon the possibility of differentiating a type of disorder for which no official name exists, appearing typically as an aftermath of "combat exhaustion", but sometimes without that experience.

This disorder is a disgruntled, resentful, embittered, aggressive, unamiable state in which the patient is particularly resistant and irritable about what he calls being "shoved around". He is often distrustful of treatment, resentful of hospitaland

military restrictions, without definite goal or group bonds for the expression of his aroused hostility. He feels that he does not belong to anybody and that "nobody gives a damn" for him. This condition is often colloquially designated "fed-up" or "all browned off", or by some more pungent term of army slang. In attempts at formal classification these cases have sometimes been labeled "anxiety state", sometimes "constitutional psychopathic state", sometimes "paranoid condition". If diagnostic labeling were merely a matter of matching clinical cross sections against a kind of standard pattern the label "constitutional psychopathic state" would have considerable justification, for there is a great deal of likeness in this clinical picture to that of the more aggressive type of so-called constitutional psychopath when he is under detention for psychiatric observation. None of the members of this Commission particularly approves the designation "constitutional psychopathic state" even in civilian use because of its customary implications of "constitutional" origin and complete irreversibility and its misuse as a psychiatric wastebasket, but the use of this designation for the "browned off" soldier is particularly unfortunate. By this statement we do not mean to express any specially optimistic expectation that this fellow is likely to become a useful combat soldier in any brief period.

The Commission suggests tentatively for this group the use of the term "morbid resentment state". The condition so designated is not intended to include mild states of resentment or those in which the resentment is realistically appropriate to the situation, but a state in which one's military effectiveness is seriously interfered with by displaced resentment, just as the morbid anxiety states are characterized by displaced anxiety.

The condition designated here as "morbid resentment state" has genetic and dynamic relationships with depressive, paranoid and anxiety states. It not infrequently follows a frankly depressed condition and may turn again into a depression or into a paranoid condition.

We recognize that the term "morbid resentment" may be open to abuse and ironic misinterpretation which might hinder its clinical usefulness, for resentment in some degree is an almost universal experience in the military situation. In our opinion, the condition which we have described is different from ordinary resentment in both a quantitative and a qualitative way. Some other term might be found which would avoid these difficulties, but we have not been able

to think of it. Whatever term is used, there should be a distinct understanding that the condition so to be designated is one in which the soldier is really thereby disabled in a military way, and does not include normal feelings of resentment, realistically justified by special experiences, which the soldier is able to keep under control and in a reasonable perspective.

We have but little more to say about psychiatric classification and nomenclature, which is admittedly in an unsatisfactory state, reflecting the present transitional phase of psychiatry in general. We believe it of little value merely to revise terms or invent new ones; the validity of the concepts is more important than the names. We do believe that military psychiatry would be helped, as has civilian psychiatry, by the practice of stating brief diagnostic formulations to supplement or to replace the single-term label, and we suggest that such diagnostic formulations may usefully include a very brief characterization of each of the following features:

1. Present clinical picture.

2. Situational influences, including for example, combat experience, treatment and management.

3. Personality, including evaluations of maturity, stability, predisposing maladjustments, and special points of vulnerability or strength significant for military service.

4. Degree of disability and expected duration.

5. Recommendations as to further treatment, disposition or reassignment.

TREATMENT

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TREATMENT

I. Introduction

From the viewpoint of military requirements, in a war which is fought far from the source of replacements, the capacity to return to duty must be the primary test of the success of any regime of treatment. It is probably safe to say that no other branch of medicine or surgery has conserved manpower for the Armed Forces more effectively than has psychiatry.

Of all neuropsychiatric casualties occurring in the U.S. Ground Forces in the E.T.O., 80% have been returned to duty. (Colonel Lloyd Thompson).

In the Canadian Ground Forces in the E.T.O. between D-Day and V-E Day of all psychiatric casualties 80% were returned to duties of all kinds, 30% to combat. (Lt. Colonel Richardson).

II. The Treatment at Successive Army Levels

To understand and to evaluate treatment in the military setting it is necessary to keep in mind the fact that this treatment must be carried on at a series of levels, each of which has its own special difficulties and opportunities. In the Ground Forces, which are our primary consideration, the first of these is the battalion aid station. Then comes a transportation unit known as the collecting company, and a halt of variable duration (up to two days) at a clearing station. Behind this is the first specialized psychiatric treatment unit, the exhaustion center, which may be set up as an independent unit, or may be part of an evacuation hospital. All of these function within the Army. They are backed up by general hospitals and by specialized psychiatric installations in the Zone of Communications (Com Z) (on the continent, the 130th General Hospital and the 51st Station Hospital, in the UK Base Section, the 312th Station Hospital and the 96th General Hospital).

The battalion aid stations are manned by young surgeons, aided by medical corpsmen. Neither the surgeons nor the enlisted men have had specialized training in psychiatry, although efforts have been made to teach them the essential nature of the psychiatric problems with which they will be confronted, largely by means of lectures and educational films. Here the main dependence is on rest, reinforced by amytal and hot food and shelter for a period up to 24 hours.

Within each Division the battalion aid stations are backed up by the Division Psychiatrist at the clearing station, where patients may stay up to 5 days. Here again rest is the primary consideration, aided by amytal, warm packs where necessary, a change of clothes, a hot shower, and hot food.

The next treatment point for a patient in the chain of evacuation is the exhaustion center. Here ordinarily he will stay anywhere from 5 to 20 or 25 days. Wherever possible, the exhaustion center is in charge of a physician who has had some psychiatric training. He is assisted, in turn, by younger physicians who have shown some interest in and aptitude for this work and many of whom have had special Army courses in military psychiatry. There are no nurses in the exhaustion centers. The Army Psychiatrist supervises and aids in the work of the center. The exhaustion center depends primarily upon prolonged narcosis and general physical rehabilitation, with some use of abreaction techniques.

Finally there are the general hospitals and special psychiatric hospitals in the Zone of Communications. These are staffed by men with neuropsychiatric training, by nurses and by medical corpsmen. Its varied procedures will be described in detail below.

A. The Battalion Aid Station

The problem that faces the Battalion Surgeon varies both in kind and in volume with the severity of the fighting. Under conditions of static holding operations, the ill, the wounded and the emotionally upset soldiers are admitted at a fairly steady and predictable rate, which makes it possible to examine each patient with some care and to treat him appropriately. When fighting is heavy, however, patients come in such large numbers that the Battalion Surgeon can do little more than ascertain whether the patient is wounded, or has an acute illness, or is otherwise disabled. The soldier is examined by the Battalion Surgeon, who must decide promptly whether he should be allowed to remain a few hours or overnight at the station for a regime of rest and hot food or whether the validity of his complaints should be challenged and the soldier returned to the front line forthwith.

Many factors enter into this decision: The urgency of the military needs at any moment, the bias which the Surgeon brings to the problem, the pressure under which he himself is working, the criticisms or pressures to which he may have been subjected by his superiors, and his own prior experiences with the problem. We were told by Division Psychiatrists that some Battalion Aid Surgeons took a "hard-boiled" attitude and prided themselves on sending back to

immediate duty all who were not so disorganized psychologically as to endanger the safety of their units. Some had passed through various phases in their experience with this problem and had shifted from initial leniency to greater sternness and then perhaps had finally found a happy mean.

Because no records are made on men not sent to clearing stations, it is not possible to say what percentage of the men who come to battalion aid stations on their own initiative or what percentage of those who are sent by others are sent back to combat at once. Nor is it possible to say what percentage of those who were ordered to return to the fighting subsequently became ill.

Those who are allowed to remain at the battalion aid station are given a chance to sleep, a sedative (usually sodium amytal grains vi-ix) and hot food. By the next day a certain number of these patients are ready to resume combat. However, no records are kept of such returns. It is the Commission's impression that among the soldiers who received this treatment were many who were thereby enabled to return to combat and who thereafter were able to carry on for a considerable period. Just how long, would naturally be influenced by the severity of subsequent combat stresses. Undoubtedly, however, there are others in this group who sooner or later relapsed with more serious difficulties and required evacuation to the rear.

In estimating the therapeutic value of the treatment which was described as occurring at the battalion aid level, your Commission was deeply impressed by all that it means to the soldier to receive understanding and help at that moment.

He finds at the battalion aid station a physician, with all that it means at such a moment to come under the care of a doctor. Furthermore this physician is an officer who is sharing the fighting soldier's dangers, yet who is there not to participate in the violence of combat but to protect and help him. The same thing is true of the medical enlisted men. It means a great deal to find that within the combat team with which he is so deeply identified, there are members whose job is care and protection. At a moment when his identification with his unit is in jeopardy, this is of great importance, and helps to maintain his sense of unity with his group. All of this has a significance to the soldier on every psychological level. It means a return to a world which is not completely dominated by hate. It means a link to home and to being protected. It signifies the power of a civilized world behind him that cares about what happens to him and looks out for him. It is impossible to overestimate the deep emotional and symbolic significance of these elemental human services to the soldier who is exhausted in body and in spirit. What any specific techniques add must be evaluated against these primary values.

Yet firmness also had its place here. Too much warm care, too long maintenance may make it more difficult for a soldier to return to combat. The Battalion Aid Surgeon has to find a balance between giving the soldier just as much of this as he needs, without destroying his willingness and his ability to meet the overwhelming emotional stress of modern warfare. A stern attitude has often quieted a jittery soldier and aided him to return to combat. Some have even thanked officers afterwards for expressing this attitude.

B. The Evacuation from the Front

Not much was learned by the Commission concerning details of the experiences of patients during their transportation to the rear from battalion aid stations. It was reported that sometimes important changes occurred during this initial step in the process of evacuation. Usually they were given additional sodium amytal for the trip.

C. The Clearing Station

Psychiatric casualties usually remained in clearing stations about 2 to 3 days. Here they received their first careful psychiatric study from Divisional Psychiatrists. And here they are usually treated further by sedation with sodium amytal, occasional packs, rest, and general restorative care. The clearing station thus serves both as a further step in treatment, and as a triage point, where patients may again be returned to combat, or sent to the rear to general hospitals or to exhaustion centers for further care.

As the lines of communication became extended, it was sometimes necessary and possible to transport patients from clearing stations to exhaustion centers by air transport. Delays and bottlenecks were not always avoidable; and at times this meant that a patient would pass through three or four medical installations on his way to his first specialized psychiatric treatment. Your Commission was unable to examine any over-all statistics on this, but such delays, while frequent, did not seem to be the rule. Naturally and inevitably they complicated the subsequent therapeutic problem where this occurred.

D. The Exhaustion Center

As originally planned, treatment at the exhaustion center level was intended to last for not more than 7 to 9 days. Inevitably the policy has varied from time to time and in different installations, when the intake of new patients decreased or when there was delay in evacuation to Com Z. Under these circumstances the exhaustion center sometimes held patients for several weeks and undertook definitive

treatment. When this occurred it functioned essentially in the role of the specialized NP Hospital of the Zone of Communications which will be described below. We will describe here the activity of the exhaustion center when it is performing the function for which it was designed.

The Commission feels that it is well to record a comment which it heard on innumerable occasions. This was to the effect that the exhaustion center never operated as effectively as it could have because of the lack of its own T/O and T/E. This handicapped the centers as to personnel of all ranks, and limited its mobility.

In ETOUSA the exhaustion centers in the 1st, 7th and 9th Armies functioned as independent and separate medical installations. In the 3rd Army, on the other hand, its functions were assumed by an evacuation hospital.

The Commission is not qualified to pass judgement on the relative merits of an independent exhaustion center as opposed to an exhaustion center set up as a special division of a general evacuation hospital. For the latter plan, Lt. Col. Talkington advanced the argument that it made possible easy access to other medical specialists for consultations, and a freer use of general medical, surgical and laboratory facilities. He also emphasized the value of the joint use of the convalescent camp as hospital within the Army, with its 3000 beds and 250 neuropsychiatric patients. Your Commission feels that in attempting to form any judgement on this issue it would have to be in a position to secure objective evidence as to the influence of each type of installation on:

1. The therapeutic efficacy of the psychiatric regime.
2. The stigma attached to the psychiatric casualty.
3. The educative influence on other physicians.
4. The effects on administrative problems of including psychiatric units in installations created primarily to deal with surgical casualties. In this last connection it may be worth while to record the impression that at least in certain instances the Commanding Officers of evacuation hospitals would have been happy to be rid of the complications resulting from the inclusion of a psychiatric unit.

In all exhaustion centers essentially similar forms of treatment were used. Continuous narcosis, techniques of abreaction, either under hypnosis or under brief narcosis, physical recreation, reassurance and an opportunity to ventilate personal problems during personal interviews with the psychiatrists were used in varying combinations, depending upon the pressure of work, the varying intervals

which had elapsed since the onset of illness, and the special experience and training of the psychiatrist. Some laid stress on narcosis, some on physical rehabilitation and training, some on abreaction, and some on sustained contacts between patients and physician or between the patient and a carefully selected wardman. When the unit was under heavy pressure, the general policy seemed to be to give the patients one or two days of narcosis. More detailed discussion of these procedures will be reserved for the section on specialized psychiatric hospitals.

The reports on the number of cases returned to duty from exhaustion centers are not always strictly comparable. From the 9th Army, Lt. Col. Cavell reported that between December 1944 and March 1945, 55 to 60% returned to duty; and that of these from month to month, one-third to one-half returned to combat, and one-half to two-thirds to non-combat duties. For the 3rd Army, Lt. Col. Talkington reported 50% returns to duty, of whom two-fifths went back to combat and three-fifths to non-combat duties. Of the 50%, a part were sent to convalescent hospitals within the Army and the rest were evacuated to Com Z. For the Canadian Army in the European Theater, Lt. Col. Richardson reported more conservatively that about 30% returned to duty from what is equivalent to our exhaustion center. Brigadier J. R. Rees reported that after D-Day, of 5000 neuropsychiatric casualties from the 21st Army Group, about 90% returned to duty from exhaustion centers and about half of these to combat. It may be significant that this Army group was subjected to intensive psychiatric screening just prior to D-Day.

It was not possible for your Commission to reconcile these divergent statistics. The impression was gained, however, that the divergencies may have been more apparent than real, and represent different statistical groups or administrative procedures. The general problems which confronted your Commission in any attempt to evaluate such statistics will be discussed in a special note below.

Some information was obtained as to the durability of the recovery of men on return to combat duty from medical installations within the Army. Within the 3rd Army, Lt. Col. Talkington reported that of all neuropsychiatric patients returned to combat duty, a few had been decorated, 23% had been wounded, and that after six months 3% remained in the line, which is the same percentage as obtains for riflemen in general. From the 7th Army, Major Ludwig reported that in a follow-up of 338 psychiatric patients returned to combat duty within the Army, he had found that 178 (53%) had remained with the Combat Unit for more than 30 days, and 63 of these (19%) for over 60 days.

E. Special Neuropsychiatric Hospitals in the Zone of Communications and in Neuropsychiatric Sections of General Hospitals

1. The Practical Value of Such Hospitals

Three of these hospitals, (the 130th at Ciney, Belgium, the 51st at Luneville, France, and the 312th at Shugborough Park, Stafford, England) aim primarily at the treatment of psychoneurotic and allied disabilities. The 96th at Malvern, England, is devoted primarily, but not exclusively, to the care of psychotics. The need for these hospitals grew out of the loss of manpower which had been occurring through inadequate treatment of psychiatric disabilities prior to their organization. Thus the return to duty for neuropsychiatric patients from the 2nd, 5th and 30th General Hospitals was only 25%. When the 36th General Hospital became for a time a neuropsychiatric hospital, the return to duty soon rose to approximately 60%.

From the 312th General Hospital, Lt. Col. Lewis Loeser reported 80-85% returns to limited duty, and from among these a 10% voluntary return to combat duty. He pointed out, however, that there were periods in which for various reasons the returns to duty had dropped as low as 67%.

A similar experience was reported from North Africa, where prior to the organization of special facilities for the treatment of psychiatric casualties, 85% of such patients had to be returned to the Zone of the Interior. After the organization of special facilities the return to duty rose gradually to 75%; and between December 1943 and March 1944 the return to combat rose to 30%. (Hanson, quoted by Ludwig).

Thus there would seem to be no question of the value of special hospitals for the treatment of psychiatric casualties at this level. Furthermore, in a recent follow-up on 500 patients returned to duty of all forms from the 312th General Hospital, between August 1944 and April 1945, 80% were still on duty in the E.T.O. and some of the 20% had developed other ailments or had been killed or wounded in action (Colonel Lloyd Thompson).

2. Therapeutic Procedures in Use in Neuropsychiatric Hospitals and in Neuropsychiatric Sections of General Hospitals

Patients reach these hospitals at intervals after the onset of illness which vary from a minimum of approximately two weeks to many weeks. Most of them have been through several medical installations on their way, and frequently various therapeutic

procedures have been attempted with them, some of which will be repeated more intensively and at greater length when they reach the psychiatric hospital in Com Z. These procedures, which must now be described and discussed in some detail, consist primarily of: prolonged narcosis, modified (sub-shock) insulin, various combinations of these two, abreactive techniques under hypnosis or under brief narcosis, occupational, recreational, and social therapy, physical rehabilitation, various forms of psychological treatment, both individually and in groups, and finally special regimes for military rehabilitation. Originally this program was planned to last three to four weeks. Recently this was extended to sixty days. However, sometimes a not inconsiderable portion of this time had been consumed in transit. Before describing these treatments it is necessary to point out that the patients who reach these installations in Com Z constitute a group that has failed to respond to treatment in the battalion aid station and the clearing station or in the exhaustion center.

a. Prolonged Narcosis:

Prolonged narcosis is administered in various ways. At the 130th General Hospital, it is rarely used alone, but usually in combination with insulin. It is recommended for use alone only in forward areas where insulin is not advisable. It was formerly used for seven days, but now is restricted to a maximum of two days. Repeated doses of sodium amytal grains vi were given with a maximum daily dose of 30 Gr. Wherever this amount was ineffective, 4 - 6 c.c. of paraldehyde was given about one hour after each dose of amytal, up to a daily maximum limit of 30 c.c. Emphasis was placed on wakening the patient for personal hygiene three to four times a day, on deep breathing exercises every morning to prevent atelectasis, and on the use of 50 to 60 units of insulin at the end of the period of continuous narcosis to prevent convulsions and severe "hangovers". At the 312th Station Hospital deep narcosis was given for three days, but after the first day it combined with insulin as will be described below.

In the 8th Air Force (USAAF) Major Bond reported the intensive use of sodium amytal up to a total of 25 grams, administered over a three day period, with an average dose of 8 to 10 grams. He felt that this was of no value if given later than 2 weeks after the onset of the illness. However, if it was administered within 2 weeks of the onset and followed by 2 weeks of intensive physical rehabilitation 14-20% of the mild cases and 3% of the severe cases returned to combat flying.

Lt. Col. Main reported from the Northfield Hospital (British) on the use of continuous narcosis for periods of

4-10 days. Somnifen and amytal were used but "only because they were most readily available". Col. Main stressed the importance of the psychological meaning of the deep sleep experience to the patient, and of the psychological implications of the patient's behaviour and of the behaviour of the nurses toward patients under narcosis. The patients were allowed and encouraged to regress to infantile acts and attitudes. They were fed when they seemed to want it, with their heads on the nurses' shoulders. When sucking movements occurred they were allowed to take milk from a bottle. One patient emptied 17 small bottles before this oral drive was appeased. Nursery rhymes were recited or sung to the patients on request. The return to full consciousness was treated as a weaning experience, through which they were allowed to pass slowly. It was Col. Main's impression that the 48 hours which was all they could allow to this process was inadequate, and that four days would have been more satisfactory. Patients were carefully selected for this treatment, during the 24 hour to 48 hour period of initial observation.

Several observers have commented on the large number of significant emotionally charged memories and attitudes which patients may express from time to time while under such a regime of continuous narcosis. In certain institutions this material is used to guide the relationship of the physicians, nurses and attendants with the patients while under narcosis, and in subsequent explorations. In other installations emphasis is laid on the point that the patient tends to be amnesic for such revelations when he wakens, and that he appears to find no relief merely from voicing these dreamlike thoughts. To these physicians it has seemed unwise to make much use of data obtained under deep narcosis. The Commission feels somewhat sympathetic with the former point of view but recognizes that many factors, and above all the pressure of work, would determine how much can be done in this direction.

As is well known prolonged, continuous narcosis is not without its dangers. Major Bond reported two deaths in a large series, at least one of which, however, may have been a suicide. Others have emphasized the importance of protecting the patients against convulsions during the withdrawal of the drug. Some have recommended phenobarbital for this purpose and others the use of insulin.

b. Modified Insulin Treatment:

As has been indicated, the evaluation of modified (sub-shock) insulin cannot be entirely separated from the evaluation of prolonged narcosis because the two are now combined

in many installations. However, certain differences in technique and certain differences in the uses to which it is put are worth recording.

The staff at Bellsdyke Hospital (British) used insulin in cases which developed some tendency towards chronicity and who gave a history of poor sleep, physical malaise, sweating and possibly some weight loss, although this last is not emphasized. They began on the first day with 10 units at 7:00 a.m., and increased the dose 5 units per day to a maximum dosage of 35 to 40 units. This regime was maintained for three or four weeks. At 9:30 a.m., the patients were given their breakfast in bed by other patients who just completed this treatment. Sleep was not invariable, nor was sweating or other mainifestations of autonomic discharge. The gains in weight have not been remarkable; but irrespective of such gains, in the carefully selected group of patients on whom this regime was used, there was a marked subjective improvement. The patients almost universally developed a sense of physical well-being which laid a foundation for the psychotherapeutic measures which occupied the rest of their days from breakfast to bedtime.

The procedure used by Lt. Col. Loeser at the 312th and by Major Kelly and Lt. Col. Lomkau at the 130th forms a rather sharp contrast to this. At these installations, the initial dose of insulin was usually 40 units; and this was increased to 100 units by the 6th day. The treatment rarely lasts more than 7 to 10 days. The patients become profoundly drowsy or stuporous, are drenched with perspiration, and may approach the borderline of convulsive states, against which they often have to be protected by the use of phenobarbital. The patients receive breakfast at 11:30, and their lunch immediately thereafter, and in the afternoon engage in the general psychotherapeutic regime of the hospital.

In general, in these hospitals the tendency has developed to use an insulin regime which begins with deep narcosis overlapping with the period of insulin treatment which is finally continued alone. With minor modifications, this regime was applied to recent combat cases with acute manifestations, to "incipient" cases, and to those whose symptoms were becoming chronic. With the former, the combined narcosis and insulin was maintained for seven days, while in the latter groups the amytal-narcosis was dropped after two days. Emphasis was placed on a gain in weight of at least 10 lbs. Evidence as to the permanence of such gains was somewhat inconclusive.

A member of the staff at Bellsdyke Hospital reported that he had found the extremely light insulin regime useful in the relief of the symptoms of gastric neurosis.

At the Mill Hill E.M.S. Hospital, the use of insulin with continuous narcosis was recommended for "latent or delayed anxiety states". Sodium amytal was given every four hours, starting at noon and continuing until midnight. This was continued for 18 days but always combined with insulin in the morning. Phenobarbital, gr i was given twice a day for one week, to prevent convulsions after discontinuing the amytal.

At the same hospital another member of the staff reported on his experience with the use of prolonged narcosis combined with insulin in acute emotional disturbances arising among civilian air raid casualties. He had used it especially in patients who had previously been healthy and had broken down after prolonged stress and little sleep. Where there was marked restlessness and tremor he always began with narcosis. Where there was marked weight loss without much restlessness or tremor he began with insulin. Where there were marked conversion symptoms he began with "narcoanalytic abreactions".

Various arguments have been put forward for the routine use of insulin in hospitals of this nature. Its value as a ritual is often stressed because of its influence on hospital morale. Nurses and wardsmen derive from it the feeling that they are playing an active role in a therapeutic procedure which impresses them as dramatic. The patient himself feels that something is being done and derives encouragement from his gain in weight and appetite and from the relief of gastric distress.

The Commission was impressed by the amount of emotionally charged, dreamlike activity which was manifested by patients in the insulin wards. One striking example was a young soldier from a tank destroyer unit. For the first few days, under increasing doses of insulin, he remained in a state of great emotional torment both during the day and night. After each session under insulin, he would be aware that he had had violent dreams of which he could remember nothing. After the 6th such session, during which he ha d been particularly violent, he awoke peacefully and remembered a dream in which he was not in a tank destroyer but in a tank which had been hit and which was burning up. Out of this dream he awakened in a state of quiet calm, with mild depression.

c. Techniques of Abreaction

The evaluation of abreactive procedures and of those abreactive states which occur spontaneously presents many difficulties. Certain theoretical aspects of the problem will be discussed in a special section below. This section of the report

will be concerned largely with observations made by the Commission and the accounts of the experiences of others which were communicated to it.

Abreactive states have been variously induced under hypnosis, under brief narcosis with amytal or pentothal or pentothal followed by coramine, under ether, and under nitrous-oxide-oxygen. Various opinions have been expressed by those who have worked with these methods, indicating divergences which are due in part to differences in the clinical conditions which have been subjected to the treatments, in part to differences in the way in which the treatment has been used.

Major Douglas Bond, 8th Air Force, came to the conclusion that with their material, abreaction under pentothal has only a "revelatory" and not a therapeutic value. Similarly, Lt. Col. Loeser reported that abreactive techniques had been used less and less in the course of time. He emphasized particularly the tendency away from "specific desensitization" and away from "dramatic tricks", and a tendency to focus more on "general catharsis". Dr. W. L. Rees of the Mill Hill, E.M.S. Hospital, reported that he found nitrous-oxide-oxygen to be of little value, because the effect was too brief, and only a small proportion of patients so treated were productive.

On the other hand, Dr. Rees felt that in his hands narcoanalysis under pentothal had been helpful if care was used both in preparing the patient for the treatment and in his after treatment. He administered the drug slowly, maintaining rapport throughout by free conversation and trying to elicit as much material as possible before the patient was completely under the effect of the sedative. He felt that it is equally important to continue to review this material as the patient is emerging from the sedative effect, when fully awake, and again within a few hours. He found that after an interval of a day or so had elapsed, recurrence was almost certain. In his use of narcoanalysis, he limited his goal largely to the relief of symptoms and to the facilitation of social readjustment. He reported that in a comparison of 200 cases treated in this way and 200 treated in various other ways, he could find no statistical difference in the ultimate outcome. Nevertheless, he felt that the sharp focusing of the attention of both the patient and of the physician on important problems led to a period of more intensive therapy, and in the end saved a great deal of time.

Major Kelly reported on the results of the use of abreaction under light ether anesthesia with 80 cases at the

130th General Hospital. Of the 80 cases, three had been sent to the Z.I., 58 to limited duty, two to combat duty; and at the time of this report 17 were still in the rehabilitation section. Most of these still manifested some sensitivity to noise, but this was said to be diminishing. The use of ether regularly involves a stage of excitement and the excitement and struggling were considered to have special therapeutic value.

Major Howard Fabing at the 130th General Hospital demonstrated the technique which he had developed for the treatment of cases which he considered to be in some special way related to blast effects, without direct contact trauma to the head. The report of his work is being submitted in full by Major Fabing and need not be analyzed here. Certain aspects of it, however, are of general interest.

In the first place he evolved a technique of abreaction somewhat different from that used by anyone else. In doing so his results, as judged by return to duty and freedom from subjective complaints, rose from less than 50% to 90%, thus bringing them into line statistically with the results generally reported in the treatment of combat exhaustion.

With abreaction under ether he had nine returns to duty out of 21 cases. With pentothal alone he had 10 returns to duty out of 15 cases. With the technique which he finally evolved, using pentothal followed by coramine, he had 53 successes out of 58.

His method was as follows: he gave a dose of 1/150 grain of atropine. Then under pentothal he attempted to reconstruct with the patient the history of the entire period for which the patient was amnesic. Having gone over this story in the fullest possible detail, and while the patient was still under pentothal, Dr. Fabing suddenly and dramatically attempted to reproduce the situation with sound effects, as though the patient was still in the midst of battle. At the height of the patient's excitement, he injected 10 c.c. of coramine. Thereupon the patient wakened in about 45 seconds, sneezed violently for a minute or so, andthen immediately continued the review of the material which had just been recovered. In subsequent hours this review was repeated several times both with a special wardsman assigned to the patient and in writing.

The only symptom that was regularly resistive to this treatment was the sensitivity to noise, which however was said to be improved. Two patients were free of it and voluntarily

returned to combat duty. In this connection it is interesting to note that the memory of the sound of the explosion is never recovered. Major Fabing concluded that the sound never registers in consciousness.

Major Fabing also pointed out that it had been possible to achieve the same results in two cases by means of abreaction under hypnosis, with the aid of Capt. Oscar Legault. Lack of time made it impossible to make extensive trials of this method.

The Commission had few opportunities to observe the use of abreactive treatment under hypnosis. Reports of its use at the 51st Station Hospital in the hands of Captains Farber and Brauer were presented to the Commission by Major Paul. Unfortunately, however, the absence of Captains Farber and Brauer made it impossible to inquire into their experience fully.

At the 96th General Hospital, the Commission had an opportunity to observe an abreactive treatment under hypnosis but due to the lack of time the session was limited to the demonstration of interesting clinical phenomena and afforded no opportunity to appraise therapeutic value. In general, although there was interest everywhere in the possibilities inherent in the use of hypnosis, it seems to have played a relatively minor role in the activities of the psychiatrists in the E.T.O, no doubt partly because the use of this technique requires more experience. Limitations in training plus the tremendous pressure under which so much of the work has had to be done seems also to have led to a tendency to focus abreactive sessions on combat experience alone. Even where no deliberate attempt is made to induce a regression in time to early life, such temporary regressions often occur spontaneously in a patient who is under hypnosis or under sedation, just as it does in spontaneous dreams, because not infrequently the pathogenicity of the combat experience is in part due to the fact that it has reactivated disturbing earlier problems. The Commission presumes that the tendency to limit inquiries strictly to combat material may not infrequently have led to the exclusion of earlier data about which the patient needed helpful understanding in his effort to achieve mastery of the illness which had been precipitated by combat. In inexperienced hands this conservative policy is undoubtedly safest. However, as Major Bond pointed out, the identification with those who have been killed or mutilated is often complicated by concealed hostility and is thus linked directly to guilt and fear, the roots of the hostile identification being, in his words, "deep, old, and displaced". He pointed out that in such instances, it was sufficient sometimes to deal only with the identifications, sometimes with its hostile implications, and sometimes with the displaced origins of these

feelings. Undoubtedly the pressure of time and deficiencies in technical psychiatric training frequently make it necessary and wise to leave untouched much of the material of this nature which is made available in abreactive procedures. This practical necessity should not, however, lead to a premature undervaluation of the potentialities inherent in these techniques in experienced and skillful hands. Further discussions of them will be found in the section on general principles below.

The so-called "chemical abreaction" techniques which have been used so extensively in military psychiatry, depend upon chemical agents to force through brusquely an experience which, in civilian practice, has been ordinarily approached more slowly and handled more gently and in which much importance has been attributed to the role of the psychiatrist in helping the patient to relive his crucial experience in a different way, digesting it, so to speak, rather than rejecting or attempting to repress it. The objective of military abreaction is similarly formulated, but some of these psychologically important implications seem to have been ignored at times. In installations which operate on the "conveyor-belt" plan, with a change of physicians at every step in treatment, the patient may be given very slight opportunity to establish any personalized emotional relationship to the psychiatrist before getting the "shot" of induced "abreaction", and may have very little chance then to do anything more than recall the traumatic experience. There are, however, some features of the situation which may in certain instances tend automatically to mitigate these handicaps. The general atmosphere of a given hospital supplies a kind of "halo" effect which may orient the patient emotionally to the individual psychiatrist, sometimes in a manner helpful in the abreaction, sometimes not.

In witnessing some examples of brusque "abreaction", induced by chemical means, we noted also the gentle and considerate manner in which the wardmen cared for the patient immediately after the "abreaction", and we consider this an important feature of this therapeutic method.

d. Treatment of the State of Mourning

At Northfield Hospital Lt. Col. Main described a particularly interesting method of dealing with those profound mourning reactions which frequently arise as a reaction to the loss of comrades. Here he felt that the difficulty lay in the patient's conflict over accepting his mourning feelings. He made no effort to trace this reaction to an unconscious hostile attitude or to earlier conflicts in important human relationships.

Instead, he encouraged or sometimes even forced the patient into a week of intensive mourning. He prescribed solitude, unashamed weeping and rituals of expiation, such as partial fasting and abstention from all amusements or distractions. At times, he reinforced the role of the patient's own conscience, and made more articulate the patient's unspoken self-accusations. From this procedure Colonel Main reported satisfactory therapeutic results, which he compared to the relief of profound grief in units of the British 8th Army when they were allowed to express that grief in formal burial rites with appropriate ceremonies and muffled drums.

e. The Use of Ergot

Recent reports claimed that gynergen in doses of 2 mgms. given 6 times a day for 7 days was valuable in the treatment of severe anxiety states. This was tested at the 130th General Hospital. One group of patients received lactose tablets and the other group received gynergen capsules. After one week one-third of those receiving lactose had become free from symptoms, and one-half of those receiving gynergen. No complications occurred.

The test was repeated with similarly negative results with other ergot preparations. During the treatment the patients had poor appetites, lost weight, showed a drop in blood pressure and had some pain on the inner aspects of the thighs.

f. Group Psychotherapy

There can be little doubt that innumerable elements in the interpersonal relations among patients, and between patients and (a) enlisted men of the Medical Corps, (b) nurses, and (c) doctors exercise an important influence on the recovery process. Much of this is spontaneous and unguided. It has been described above in terms of what it means to the patient at the battalion aid station to receive the ministrations of the medical corpsmen and physicians. It is seen in the tremendous encouragement which other patients receive when they observe the dramatic relief of a hysterical symptom.

Similar examples of these spontaneous group relationships could be given at every level. In the special hospitals in the Zone of Communications one sees the group interactions exerting both beneficial and destructive influences. There is a close identification between the patients and the wardmen, especially when these have been drawn from the ranks of combat men. This identification is of particular importance in building new ties among the men

and an esprit de corps in the hospital to replace their loss of identification with their own units. In this the elementary facts of eating, sleeping and playing together are all significant.

In addition to the spontaneous and unguided group influences, a more deliberate type of group psychotherapy was often used.

Group psychotherapy was described by one hospital director as the most important contribution to psychiatry gained through the war experience. Almost all psychiatric installations have found that there are many advantages in dealing with some of the psychiatric problems of soldiers in groups. The way in which this has been done, however, has varied widely.

In some hospitals, such as the 312th and Bellsdyke, an entire ward is taken as the group. Simple didactic lectures are given, dealing with the nature of fear, physical manifestations, and some of the mechanisms of psychosomatic disturbances. Out of these lectures grow discussions, and sometimes "gripe" sessions.

Other hospitals, such as the 130th, use a similar approach, but exclude from the group all of low intelligence, all aggressive psychopaths, and all severe hysterics. They introduce an individual psychotherapeutic interview early in the series of group sessions and again at the end. The special purpose of these is to investigate the need for further individual treatment. Simple autobiographical sketches are asked for as an aid both in estimating the patient's need for further treatment and in assessing his desire for help. A similar use was made of autobiographical material at the 108th General Hospital in Paris but the material was usually stereotyped and barren.

In other installations group principles were applied in other ways. Major Bion, in one of the British hospitals, organized small groups and set them certain specific tasks to accomplish without assigning a leader in order to bring out patterns of interpersonal stresses and relationships.

At Northfield, Major Foulkes organized small groups for the spontaneous dramatization of significant experiences both from early life and from the military scene. Major Foulkes was interested in encouraging discussions in these groups, along lines which have been described by Trigant Burrow.

In the same hospital patients were brought together into groups of 8 or 10 for more intimate discussion of combat experiences and the reactions to them, of home problems and of emotional attitudes towards postwar plans.

At Bellsdyke, weekly ward meetings were a regular feature. In addition, organized groups of 8 to 10 men were formed of individuals who shared some important problem in common and met regularly with the medical officer for discussions. Some had had recent combat experience; another group was composed of men who had broken down only after a latent period, perhaps after wounds or malaria; another group was composed of men who were shortly returning to duty; and still another of men who in all probability were leaving the army. The medical officer sometimes spoke briefly to his group concerning those basic principles which would have had to be discussed individually with each man; and then made each member of the group in turn serve as leader and monitor of the subsequent discussion periods which grew out of these lectures.

The Commission did not have the good fortune to participate in group sessions in American installations, such as those in which it participated in British hospitals. In spite of this it may be fair to conclude from discussions with others that the use of group techniques in American hospitals emphasized the instructional aspects of the method, whereas the British (somewhat influenced by Moreno, Burrow, and Lewin) showed a greater enthusiasm for the spontaneous, emotional and socializing uses of the method.

g. Program of Physical Rehabilitation

All installations have made extensive use of programs of physical restoration through high caloric diets,

supplementary nourishment and vitamins and graded physical exercise

h. Program of Occupational Therapy

Occupational therapy seemed to play little role in the treatment regimens before the patient reached the hospital in Com Z. Here, all patients who were to be returned to duty spent two to four weeks in a retraining unit, organized either as a subsidiary part of the hospital (i.e., the RESEC Unit of the 130th and the 312th) or in a nearby convalescent camp. In these the soldier was brought into the atmosphere of a military organization with military tasks and training, including the use of weapons and maneuvers. These served the double function of hardening the man for return to duty and of picking out those who were not yet ready. The equivalent British institutions, because of their proximity to home, served the additional function of preparing those who were to be returned to civilian life. For this reason these hospitals developed occupational therapy in terms of civilian occupations as well, and at the same time integrated the occupational program closely with the patient's emotional needs under the guidance of the psychiatrist. Social therapy became part of the reorientation to civilian life. Ward councils were organized which met to air grievances, to elect representatives to an over-all council, to publish a weekly paper, and to elect stewards who had the management and responsibility of a clubroom. This was all used in Northfield, for instance, to bring to light latent emotional problems which were then dealt with, both in the smaller group meetings and in individual therapeutic sessions.

Occupational therapy in its familiar civilian hospital form for all patients was rarely seen in American Army hospitals.

i. General Spirit

A review of specific therapeutic procedures is incomplete without a consideration of the spirit which infuses a hospital. The Commission has on many occasions felt deeply moved by the spirit manifested by all members of the psychotherapeutic teams which it had the opportunity to visit. This applies to all of those who were called upon to carry a staggering load of unfamiliar and distressing problems - the young physicians, the nurses, and the enlisted men of the medical corps. Their gentleness and devotion to their patients, together with their restraint in manifesting this, were deeply impressive. There can be little doubt that this spirit, plus an enthusiasm for the methods which were being used, constituted a powerful therapeutic force.

Furthermore, from the point of view of an esprit de corps and the ability to carry heavy burdens of work for a long time, the fact that they were always "doing something", and that the procedures were often dramatic in themselves and frequently seemed to be followed by prompt improvement, all helped greatly to sustain morale, and to relieve the frustrations and anxieties of the medical personnel. It is doubtful if the same high level could have been maintained if more passive procedures had been used. In turn, this high morale must have affected patients who often arrived "browned off" because of the number of futile weeks they had spent going from hospital to hospital.

Under these circumstances, however, when so much is attempted with so much enthusiasm, a feeling is likely to develop that if the patient does not get well then everything possible has been done and there is nothing further that can be attempted for him. Sometimes also a certain resentment develops towards the unfortunate patient who is ungrateful enough not to recover. And sometimes in some measure it obscures the critical judgement both of the physician and of the patient, who, feeling the physician's warmth and enthusiasm, may pretend even to himself that he is well before this has actually been achieved. Thus the Commission came to feel that this enthusiastic spirit and high morale held both great therapeutic implications and certain practical dangers.

III. Special Problems

A. The Role of the Psychiatrist in the Military Setting

The role of the psychiatrist as therapist in the military setting is not identical with his role in civilian practice. He has one possible advantage, in that his patients must come to him when any line or medical officer thinks that they are in need of his help, and irrespective of the vividness of that subjective awareness of need on which the civilian psychiatrist must wait. On the other hand, he faces many obstacles. He must get his patient well promptly for return to combat if possible. He thus becomes in a sense the arbiter of life and death, or at least of health and long illness, when he sends a man back into the line because he is needed there and can take it for a time, but knowing that further breaks are due to happen.

His rank and military status emphasizes the authoritative aspects of his relationship to his patients, and in turn their subordinate role towards him. This distorts and limits the freedom with which their mutual relationship can be manipulated. In this

connection the experience of the British with civilian psychiatrists in E.M.S. hospitals is worthy of comparative study.

He works within rigid and prescribed time limits, imposed by military necessities; and he works against extraordinarily powerful secondary gains and secondary blames; the gain at escaping the hazards of battle, and the deep blame for failing to face up to the risks which his fellows are running. Finally he usually works under conditions of great professional isolation, and under the pressure of an incessant compelling necessity to prove his usefulness statistically to his skeptical colleagues, all of whom feel that the psychiatrist is doing something much more "respectable" when it has a familiar physical clang than when he makes use of purely psychological levers. All of these factors modify the effectiveness of the therapeutic functioning of the military psychiatrist.

B. Special Difficulties in the Statistical Evaluation of the Results of Treatment

1. Clinical Nomenclature

Military regulations and a desire to avoid using diagnoses which carry damaging connotations has made necessary the use of a restricted list of diagnostic terms. Consequently many patients, whose clinical conditions show marked differences, are grouped together under a few categories. For this reason a statistical survey of the results of therapy attained in any one of the accepted categories could not prove very enlightening, without a careful study of individual records and preferably a reexamination of the individual patients in person.

2. The Military Criteria for Therapy

From the point of view of military requirements, the ultimate test of recovery is a man's ability to return to duty and preferably to combat. In ordinary medical practice we do not limit our concept of health to so specialized a pattern. We do not expect to enable every patient to accept a closely regimented life or to face abnormally hazardous and unpleasant tasks. Consequently although the military need for return to duty is an imperative necessity, any attempt to evaluate the results of treatment from a broader scientific standpoint would have to include such questions as the durability of the readjustment, the flexible adaptability of the patient to varying situations, his probable future adjustment to civilian life, and the patient's freedom from subjective symptoms.

Furthermore, the Commission is not in a position to throw light on the question of whether in the long run those patients will be better off psychologically who have mastered their fears with little or no aid, or those who have mastered them with the assistance of any, or all, of the psychiatric procedures which have been described.

3. The Ambiguities in the Names Used for Various Treatment Procedures

The details already given illustrate the fact that in different installations and at different times any such term as "modified insulin" or "narcosis" can be used for procedures which vary greatly in dosage and duration, and in many other variables as well which play a role in the response of patients to treatment. Among these variables we may mention: the selection of the type of patient to be treated, the interval since the onset of the illness, the amount of treatment that the patient has had in the intervening time and the number of hospitals that he may have been through, the psychological preparation of the patient for treatment, the utilization of his psychological productions both while under treatment and subsequently in individual therapy and in occupational therapy, the nature and function of the nursing care, the extent to which use is made of women as well as men and of civilian as well as military personnel, and finally the extent of the influence of the physician on the future military allocation of the patient.

Since all of these variables must be considered in the evaluation of the results of any form of treatment, it would be necessary not only to study in detail the records of the treatment of each case, but to know something of the hospital atmosphere at the time that he was under treatment, and of the personality and attitude of the psychiatrist administering the treatment.

4. Statistics on Return to Combat Duty

Presumably return to combat duty is the most exacting test of the success of treatment. Unfortunately, however, there are special difficulties in the evaluation of these statistics. Many such patients by reason of their return to combat will be killed or wounded. In two ways this limits their value for the statistical comparison of results. In the first place it makes it impossible to give a conclusive appraisal of the durability of the recovery under combat stress. In the second place, survivors will constitute a selected sample, since their survival may mean either that the accidents of war have placed them in areas of less severe combat,

or else that they may have protected themselves from the full hazards of combat by lagging behind, while keeping up appearances.

Finally over and beyond these reservations as to the value of such statistics, it soon became evident to the Commission that such statistics were not available. In a war of rapid movement follow-up statistics are extremely difficult to secure because of the frequent transfers of whole divisions from one front to another, and even from one Army to another. More especially do these limitations on statistical enquiries apply to the group that is numerically the largest (and most important) for the conservation of military manpower. This is the group of men who succumb after intense combat, but only for a few hours or a day, and who after treatment by means of rest and nourishment at battalion aid stations are returned immediately to combat duty. The subsequent histories of these men is the most difficult of all to ascertain, yet would in many respects be more enlightening than any others.

C. General Considerations Concerning Certain Special Problems Underlying Treatment Procedures

1. The Handling of Overwhelming Psychological Disorganization

Not infrequently in the early phases of illness in the battalion aid station or at the clearing station or even as far back as the exhaustion center, the patients may be exceedingly disturbing to other patients and therefore may require heavy sedation for the sake of the others as well as for themselves. It has seemed to many medical officers that heavy sedation was of value in such conditions both in resting the exhausted soldier and in bringing him back into contact with reality. On the other hand some psychiatrists such as Major Ludwig and Lt. Col. Froelich, feel that the same goals can often be achieved by means of individual contacts alone without the aid of sedatives. Several observers suggest that the immediate routine use of deep narcosis has a tendency to increase rather than decrease these disturbances in reality relationships; and that there has been a tendency to use too much sedation and to use it too freely, routinely and repetitively.

2. General Considerations Concerning the Uses and Abuses of Continuous Narcosis

No one would question the importance of sleep in the initial care of exhausted soldiers. On the other hand prolonged periods of continuous sedation are often advocated for the care of patients who are no longer exhausted, and not merely for rest at

night, but for 20 hours out of the 24, and over periods varying from several days to several weeks. The assumption that prolonged and profound narcosis is necessarily and always healing is one about which the Commission feels certain misgivings. Wherever this point of view dominated the procedures of any installation, the Commission found that there was a tendency to neglect the important psychological content of the patient's thoughts, feelings and behaviour while under treatment.

3. General Considerations Concerning Abreactive Techniques

The Commission has already indicated its conviction that the uses and values of abreactive techniques present many peculiarly difficult problems. In the first place, it is almost certain that abreactive episodes occur spontaneously; yet these have never been carefully studied. It is also probable that an abreactive process occurs whenever a patient brings up out of his conscious and unconscious ruminations the memory of experiences which are highly charged with painful feelings, and then proceeds in a sense to relive these experiences in the supporting presence of the psychiatrist. It is certain that many soldiers are able to do this with a mature listener without hypnotic or hypnoidal assistance.

However, there are those who remain ill in spite of such efforts and who can be assisted by working with the psychiatrist under the influence of some sedative such as pentothal. This immediately presents new problems, however: problems of timing, of dosage, of the capacity to absorb and digest the material, and of the capacity to form a useful relationship to the psychiatrist. In judging such matters as this the training of the psychiatrist is of paramount importance.

The exigencies of war have forced the use of this method (which is still in the experimental phases of its development) on a condition which is still only partially understood. The British have emphasized the fact that medical officers with meager training can use these techniques safely, even as close to the front as at a clearing station if it be done gently and with the limited goal of relieving acute symptoms. The Commission has also seen the method used with considerable violence and aggressiveness. There is danger both in being too cautious and also too enthusiastic in its application but the former seems to be preferable.

There is still another way to formulate the problem. The concept of abreaction implies that unbearable emotions, which originally were linked to traumatic experiences, have been disassociated

from those experiences and that either the emotions or the experience or both have been obliterated from memory; and finally that the patient can be restored to health only by re-awakening the memory of the event, re-experiencing the intolerable feeling and thoroughly digesting the whole experience with the psychiatrist. If one accepts this formulation as a working hypothesis, it must be clear that such a procedure will at times be a dangerously harrowing experience to the patient. To safeguard the patients, some physicians depend upon the use of sedative drugs to lessen the intensity of the almost unbearable emotion.

The Commission feels that it is important to point out more fully the dangers inherent in these procedures if they are not supervised by experienced men. In the first place there is a likelihood that the inexperienced physician will go through the motions without accomplishing the essential purpose of the procedure. There is also the danger that when the patient becomes most disturbed the inexperienced physician may be overcome by his own anxiety and run away from the situation, withdrawing his support at the moment when the patient most needs him. There is the third danger that the inexperienced physician will not know how to work out the interrelationship between revelations which deal with combat situations and those dealing with the background of recent or early home problems. Sometimes this inexperience will lead to an excessive exploration of the past which may be upsetting, and sometimes to a neglect of it which will render the treatment ineffective.

ATTITUDES IN RELATION TO THE MANAGEMENT, TREATMENT AND PREVENTION OF PSYCHIATRIC DISABILITIES IN THE ARMY

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In addition to the combination of psychological and material forces pictured in the discussion of the psychodynamics and pathogenesis of combat exhaustion, the soldier who may become a psychiatric casualty in the military situation is subjected to a whole new series of emotional forces arising from the attitudes of those about him and those in authority over him in regard to the nature of his disability. These attitudes, of course, activate within the patient himself similar echoing attitudes and counter-reactions to them. This whole network of attitudinal interactions requires a good deal of consideration, not only because of its importance in determining settled policies of treatment, management and prevention, but because of its great influence, consciously and unconsciously, upon all the persons concerned with the actual administration of policies and procedures. No matter how wisely or foolishly policies may be laid down, attitudes may be in effect more significant than plans.

In the first place, aside from military considerations, psychiatric illnesses are poorly understood by the general medical profession and by the general population from whom the military personnel is drawn. This lack of understanding is not merely ignorance. Ignorance is in large measure complicated by positive misunderstanding and pernicious prejudice. The person psychiatrically handicapped or disabled is likely in the civilian setting to be the recipient either of maudlin and undiscriminating sympathy or of contemptuous and equally undiscriminating hostility or abhorrence. Each person is aware within himself dimly or clearly of some of the noxious fordes which operate to disable the psychiatric patient. Mingled pride and uneasiness over one's own "success" in dealing with such internal forces may generate an intolerant hostility toward those who unfortunately are not so "successful". Struggling against identification and sympathy one may find an uneasy internal stability in abhorrence and contempt.

In the military setting, and particularly in combat, it is hard to tolerate easily the man who cannot, or at least does not, live up to the expectations and obligations of that teamwork situation, without some obvious reason such as a wound or a fever, for such casualties immediately throw a heavier burden and a greater danger upon those who do not succumb. Pre-existing attitudes, either of hostility or of exaggerated identification and sympathy are thereby much intensified.

One of the most important functions of the psychiatrist in a military organization seems to be to deal with the attitudes of all concerned with those problems. Probably in the long run his influence on the attitudes of those in control of command functions, medical functions and staff functions, in its ultimate bearing on military effectiveness outweighs his importance in the strictly therapeutic program. It is highly important, for the best performance of these attitudinal functions, that the military psychiatrist, particularly the divisional psychiatrist in the American Army, should be a "good soldier", acceptable to his associates, speaking their language, understanding their problems and sharing their interests. He should possess those qualities of personality and those social skills which help him to work out flexible adjustments to the attitudes of his military associates and thereby to moderate and in a measure to reshape their attitudes. In our study of the matter it appeared not infrequently that the importance of such qualifications outweighed the importance of the psychiatrist's professional training in his specialty. Within the range of varying professional psychiatric qualifications, it has also appeared to us that the psychiatrists who met best these attitudinal requirements were those who had previously been primarily interested in psychotherapy and who had shown or developed outstanding competence in that aspect of psychiatric work, or those who, although perhaps sketchily trained in psychiatry, had special aptitude for psychotherapy.

These considerations led us, in our contacts with medical men, officers and others, to pay special attention during our study to their attitudes regarding psychiatric disorders. We heard a good deal of rather superficial comment on the advantages and disadvantages of being "hard" or "soft" in a general way. Such discussion often served to reveal underlying attitudes. The more experienced and mature officers were well aware of the practical necessity of discrimination as to the different methods of bringing out the best responses of different men, but we did see evidence of a good deal of rather futile groping for some universal formula for dealing with all men in all possible situations. If, in a rather grossly oversimplified way, we say that a psychiatrically disabled man may be treated as a baby or as a man or as a "son-of-a-bitch", both of the latter modes being called "hard", then we must admit that a number of physicians and even psychiatrists, did not seem to discriminate very well and tended to overwhelm the patient either with unwise babying or excessive hostility - sometimes both.

We also gained the general impression that combat experience, or close and responsible association with combat, helped some men remarkably in diminishing prejudiced attitudes and in developing a mature and realistic insight into the interplay of emotional forces at work

in men. There were, of course, others - men whose prejudices had been intensified and who gave evidence of their own uneasiness by the emotional heat and rigidity of their statements. A rough guide to this attitude was the frequency and intensity with which such persons used the term "sons-of-bitches". Moralistic preoccupations were also exemplified in the term "lack of moral fibre" employed in the R.A.F.

Hospital situations formed the main location of our direct studies. There we were dealing with groups of patients, in general, who had not been able to respond well in the simpler and somewhat "harder" conditions of battalion aid station and clearing station, - for whom therefore a certain discreet amount of "babying" at certain stages may conceivably be needed in order to help one to reintegrate with others and to regain, stepwise, a progressively more adult and militarily effective emotional orientation. Many of the enlisted men of the medical detachments whom we observed and interviewed showed a remarkable combination of tenderness and respect toward their patients, constituting in our opinion, a therapeutic agency of great value. The nurses seemed inclined toward more impersonal, executive and clerical roles, but where psychiatrists had made efforts at re-educating them and reorienting them in other directions, the nurses permitted themselves to be somewhat more maternal in attitude, especially in the care of patients under insulin treatment. This type of maternal and tender attitude in wardmen, nurses and physicians, if overprotective, may involve some danger of fostering invalidism. Like all agencies of therapeutic potency - like morphine for example - it requires discretion as to when, where and how much.

We gathered a number of comments about chaplains and the importance of their attitudes in the psychiatric program, both preventive and therapeutic. We talked with a few chaplains but were not able to make any special study of the psychiatric aspects of their work. In one exhaustion center, where the chaplain was absent at the time of our visit, we found most enthusiastic appreciation of his influence. One psychiatrist said that chaplains could be particularly helpful to the men in giving moral and religious sanction to the necessity for killing and destruction. Chaplains and Red Cross workers were also helpful to the men in dealing with problems "back home".

One point in the military scene at which attitudes make an important, though subtle, difference arises in dealing with the soldier whose condition is judged to be somewhat short of disablement and who is considered to be, in some measure, voluntarily using symptoms to evade the combat situation. If not quite construed as malingering, it is something very like it. There is evidence that

a straightforward challenging of this attitude and a firm insistence on a return to duty can make this wavering man a useful soldier. The same general procedure, done with an offensively moralistic and punitive attitude, can arouse unnecessary resentment, injure the man's self-esteem unnecessarily and give him a sense of injustice which may seriously cripple his subsequent military effectiveness.

Somewhat similar attitudinal questions arise in connection with the disciplinary problems of the unwilling or inadequate soldier and especially of the soldier charged with or suspected of "misbehavior in the face of the enemy", such as desertion or attempts to surrender unnecessarily. These cases may be very difficult for the psychiatrist. One divisional psychiatrist stated that he had established a custom of conferences with the Inspector General, based on their friendly relationship and mutual respect, so that the psychiatrist made his evaluation of the man and the situation before charges were formally filed. This plan facilitates prompt disposition through medical channels of those judged to be psychiatrically disabled. Other psychiatrists had such cases brought to their professional attention, if at all, only after charges had been filed. Cases accumulate and may come to the psychiatrist's attention long after the facts have occurred, at a time when persons familiar with the facts may have been killed or transferred to distant scenes of action.

These cases set trying situations for the psychiatrist for in effect he often holds the soldier's life in one hand and the disciplinary needs of the unit in the other hand, and has to find a reasonable balance. Some seem to agonize over this dilemma unduly, taking all of the responsibility on their own shoulders, while others are more sensibly content to pass a professional opinion and leave some of the responsibility to others.

We have no real information as to how many men who were actually disabled, psychiatrically speaking, have been convicted and executed or condemned to punishment for behavior for which they were not responsible. Nor do we really know much about the actual advantages and disadvantages of punishment as a deterrent. It is clear that one man's "misbehavior in the face of the enemy" may be demoralizing to others and also that prompt drastic action is necessary. Whether this action has to be punitive to be effectively deterrent to others we do not know. There is need for much more realistic knowledge in this field.

Perhaps the most significant feature of these problems, from the standpoint of the psychiatrist's attitudinal function, is the opportunity provided him to present, and to exemplify, to command officers

and others concerned, attitudes based upon discriminating insight into the emotional problems and reactions of men. In the same situation, these other officers have a chance to size up the psychiatrist, as to his acceptability and wisdom, and perhaps educate him a bit. This situation if things go well, may have far-reaching results in the direction of conserving manpower and gaining the maximal effectiveness of the manpower available.

This is one of the situations, and there are others too, in which the army psychiatrist may learn much from other men of great experience and judgement in handling men. The psychiatrist in civilian life deals mostly with patients who are persons functioning less well than he, and he may develop a somewhat too pretentious confidence in his judgements and formulations. Cooperative responsibilities with others may have a considerable educational value to the psychiatrist, in modifying his attitudes.

Junior officers are keymen in military action. No experience, short of actual observation of combat itself, could give a more impressive demonstration of this fact than our survey of psychiatric casualties. "The lieutenant" is a well-nigh ubiquitous figure in our case notes. He is somehow concerned in nearly everything that goes well or goes badly with the troops. He is the focal point of leadership and command functions.

"Combat exhaustion" of junior officers is therefore a matter of crucial military importance. Their disposition through medical channels or their return to combat duty, or their reassignment to other duty, calls for specially careful evaluation. We were particularly interested therefore in officer-patients. We did not see many representatives of the group who had become casualties or had proved ineffective on first acquaintance with combat or under mild conditions, but rather those who had survived long periods of active service in infantry, tank, engineer or artillery units before being sent to exhaustion centers. From the clinical standpoint, depressive features were common in these officers; hence, individual allowance has had to be made for some degrees of retrospective self-disparagement. In one of the Armies we found that the Inspector General, influenced by a senior medical man's suspicions of malingering, had insisted upon a review of each officer's case before disposition. This apparent questioning of the professional competence of the psychiatrists seems not to have offended them much, and there was apparently good mutual respect and cooperation between the layman and the doctors concerned, probably dependent upon the unusual competence of the representative of the Inspector General in handling human problems. Yet the plan occasioned considerable dealy and this period of delay, under some shadow of moral

suspicion, was very trying to the officer patients and a handicap in treatment. Had there been opportunities for useful occupation, the harmful delay produced by this suspicious attitude might have been mitigated.

The officer patients gave us much valuable information and insight into combat conditions, which we checked in some measure with officers who were not psychiatric casualties. These officers manifested attitudes of care and appreciation for their men. They had a keen appreciation of the physical and emotional aspects of long and intensive fighting. They exhibited high degrees of unit morale. It was clear, too, that they had suffered a good deal, emotionally, from the necessity of leading and ordering their men on and on to death, mutilation and psychiatric disablement. Casualty rates may be so high in small units as to give a complete numerical turnover of manpower in a few weeks or a few days. This poses a hard problem of how large a proportion of a unit may be lost while still preserving the good fighting spirit and morale which is built around the unit. This unit spirit is a tremendously important military asset, beyond the more numerical counting of bodies and equipment.

These considerations emphasize the psychiatric importance, in selecting and training line officers, of getting those who have gained or may gain a good understanding of the human being in combat and who can also maintain sufficient objectivity to manage the emotional sacrifices involved without disturbance of judgement. In this connection, also, as measures of preventive psychiatry having to do with attitudes in the military organization, we are concerned about practical methods of orienting the enlisted man by stablizing emotional ties to the higher officers of the combat organization, those not so liable to be killed quickly, so as to provide a larger and more enduring unit for his emotional identification and feeling of security, in addition to the small unit of squad or platoon, which is highly charged with emotional significance but is also highly vulnerable.

Attitudes toward men and their physiological and emotional needs have special psychiatric pertinence in the military management of rest periods, rotation, reinforcement and replacement. These constitute a wide area of command functions having a grave bearing upon the incidence of psychiatric casualties and upon the return to duty of many of these casualties. The Commission did not have as much opportunity as it wished to get personally acquainted with the attitudes of higher command concerned with policies in regard to these problems, nor with the attitudes of officers whose strategic and tactical decisions necessarily determine the possibilities of

rest and rotation. We encountered an abundance of evidence and opinion that the techniques of replacement and reinforcement, and the attitudes of men and officers concerned, were of crucial importance in weakening or strengthening the emotional attitudes and military effectiveness of the soldier.

Besides those patients for whom lack of rest and recreation had been of crucial importance, we saw many patients in whom the replacement depot situation had been emotionally destructive, so that we were tempted to use the slang term "repple depple exhaustion" rather freely and loosely to represent a major psychiatric problem. There are great inherent difficulties in managing rest and replacement when available manpower is limited; yet we saw indirect indication that the inherent difficulties had been complicated by failure at times to appreciate the full importance of men's emotional reactions and attitudes and their limitations.

A replacement policy in effect for a short time in one area required requisitioning men to replace casualties and sending them individually into frontline fighting positions at night to fill out depleted squads. The replacement might literally know no one in his squad, platoon or company, or even, if a bit confused, he might not know anything about his division, location or objectives. This practice brought the man to the crucial point of his military use stripped of many of the emotional satisfactions and supports needed for military effectiveness. Even if he did not become a casualty by wound or emotional breakdown, there was reason in this for lack of combat effectiveness and teamwork. The impromptu official assignment of some stranger as a "buddy", was quite artificial and might be emotionally disastrous if the "buddy" in an effort designed to prepare his new comrade for fighting, filled him with gruesome tales of combat experience. We were told that many such replacements promptly became psychiatric casualties.

There was a better opportunity to develop group identification and confident pride in teamwork before the crucial test came, when the plan was used of bringing up replacements during brief rest periods of the units being reinforced. Reinforcement by squads or platoons already integrated with group leaders would provide a still more effective utilization of team spirit.

Life in the replacement depot itself seems to have been a demoralizing experience for a number of men. We did not get to visit any reinforcement depots. Our information about them is all second hand or inferential. It is obvious that some plan of accumulating and shifting prospective reinforcements is a necessity of the military organization. How to manage this without seriously

crippling men emotionally is a morale problem of great importance for preventive psychiatry. We got the impression that this problem is very difficult. Anticipatory tensions were heightened by the unpredictability of assignment. The cohesive forces which had previously bound men in emotionally satisfying groups, and might prospectively afford some sense of mutual confidence and security, were generally lacking. There was a great deal of boredom and resentment of being "pushed around", with little orientation toward positive goals. Latrine rumors as to "where do we go from here", though at times perhaps destructive of morale and mostly illusory, may have served a useful psychological purpose in fulfilling the human need to have some sense of aim. The casualties who were reassigned through replacement depots, and who had had combat experience, had additional difficulty in developing and maintaining keen fighting spirit in the "repple depple" under green junior officers and in a setting where major emphasis seemed to be placed on polished buttons, saluting and other details of military dress and deportment. In some instances, we were told, such men went AWOL from replacement depots and went up to the fighting lines to rejoin their original units. Indeed, in armies which practiced rotation of fighting units through brief rests in reserve positions, the psychiatrist preferred to send convalescent psychiatric casualties promptly back to their units in such reserve positions rather than to a "rehabilitation" section or a replacement depot.

Attitudes concerned with the reassignment of those psychiatric casualties not judged suitable for combat were also sources of trouble. Although we did not get an over-all picture of the problem, and recognize that the imperative need for fighting men on special occasions may have to disrupt any assignment plan, we saw much evidence to justify the often expressed conviction of psychiatrists that more careful attention should be given to their recommendations regarding reassignment. It seems expensive of manpower, not conservative of it, to send back to combat men who are quite likely to become psychiatric casualties there, disturbing morale and demanding care and treatment again.

In the reassignment to non-combat duties of those psychiatric casualties who after treatment were judged not fit for combat, we saw evidence that quite useful and satisfactory assignments had been found in medical detachments, and that perhaps the most unsuitable reassignments were in military police.

The preceding discussion of attitudes in regard to rotation, replacement and reassignment requires, however, some acknowledgement of the exigencies of unexpected military situations. It is obvious that the commander in the field may find his forces in a situation

which calls for the emergency employment and expenditure of manpower in disregard of the ordinary principles of training, preparation and integration of the soldier in his fighting unit. At certain times in the ETO (as in the Belgian "bulge") such desperate and challenging situations have evoked magnificent reactions in extemporized fighting units. Yet there are also evidences, in the histories of patients and in medical reports, that there has been unnecessary disregard for men's limited powers of endurance and disregard for the emotional factors which may cripple their military effectiveness.

We saw numerous evidences that appreciative attitudes in regard to such emotional and physiological considerations had developed in leaders after much military experience. This is a feature of good leadership, and we found a high measure of agreement among psychiatrists that the most important factor in preventing combat exhaustion is good leadership. From this standpoint, leadership was not always good. One psychiatrist said: "Some line officers treat men worse than they treat jeeps". Attitudes of this sort should, we believe, be an important consideration in the selection, training and advancement of officers. Some officers learn "the hard way", through bitter command experience; some do not learn at all; others have much insight by disposition and pre-military experience. "Learning the hard way" involves wastage of manpower and loss of fighting effectiveness. In respect to this matter, we heard from many persons that much good had been accomplished by the circulation of Appel's psychiatric report on the Mediterranean Theater.

It was also encouraging to find that the Chief Surgeon, several army surgeons and others in positions of medical authority, appreciated psychiatric problems and principles and were using the available psychiatric talent to good advantage. Such appreciative understanding was not universal. We encountered men in charge of medical and surgical services who still seemed unaware of psychosomatic implications. We even saw some psychiatrists whose attitudes seemed unreasonably moralistic and hostile in regard to psychiatric casualties. There is still much need for psychiatric education. There seems to be a very general need for better training in group psychology.

This whole discussion of attitudes would be incomplete if it did not consider what is perhaps the most important attitude of all for a successful army - the universal sharing in a united effort to impose our will upon the enemy and a universal expectation that every man will participate therein to the limits of his staying power. The maintenance of this general attitude is a primary condition of successful war. All our comments on attitudes that have to do with psychiatric problems are offered here on the distinct

understanding that they are secondary to this chief consideration. Procedures and policies for the care and prevention of psychiatric disabilities, like those concerning other medical matters, must be designed and carried out in a manner consistent with this main attitude.

The word "morale" has been frequently employed to indicate the complex set of attitudes, feelings and beliefs which motivate the soldier to participate fervently in this united effort. Morale, in this sense, is one of the most important influences in preventing psychiatric disabilities in combat and in favoring prompt return to effective service. It does not seem appropriate for the Commission to undertake an elaborate and definitive discussion of this complex matter of morale in all its ramifications, but our observations in the European Theater of Operations have led us to certain opinions particularly pertinent to the fighting zone. There, effective morale becomes essentially a matter of team spirit, confidence in equipment and methods, and faith in leaders.

The soldier's morale benefits a great deal by information as to tactical objectives and the strategic reasons for certain desperate or disagreeable actions. Conversely his morale suffers a great deal when he feels that he is being shoved blindly about. Most soldiers, we found, recognize realistically that tactical situations may change rapidly and require sudden changes in tactics, of which they cannot always be informed, but their sense of significant personal participation is greatly enhanced whenever it is possible to give adequate and appropriate briefing. Familiarity with the good points of weapons and information as to their effectiveness against the enemy contribute also to the soldier's fighting morale.

At earlier stages there are advantages in intellectual formulations justifying the war, in the emotionally effective presentation of the issues, and in other general social and religious sanctions for organized killing and destruction. Individual soldiers who become troubled again by these problems in the theater of operations may need individual discussion with the chaplain, with the I & E Officer or with some other available and competent person; but general discussion and preoccupation with the question "Why do we have to fight?" is not helpful to the fighting man and should not be forced upon him. For him the more useful preoccupation is "How to win the fight".

In the theater of operations letters from home are of enormous importance. Good letters are powerful supports to morale. Bad letters may be powerfully destructive. The nostalgic effect need

not be deplored for it adds to the emotional value of victory and maintains the sense of emotional solidarity with one's own people and thereby helps to counteract a very real tendency in the fighting zone for the soldier to identify himself more closely with the enemy soldier who is right there in the same section of hell and has to "take it" too. Campaigns to indoctrinate hate seem of dubious value and may sometimes backfire because of unrealistic details and the soldier's resentment of obvious propaganda.

The Commission was particularly interested in the morale of those groups with whom we had most contact - the doctors, nurses, and those enlisted men working in medical installations. We saw a great deal of value in conferences of division psychiatrists called by the army psychiatrist for the discussion of common problems, policies and difficulties, for the airing of grievances and for the formulation and exchange of administrative and clinical suggestions to one another and to the army psychiatrist. Combat conditions permitting, some of the battalion surgeons could usefully be included in such conferences. If division psychiatrists as well as army psychiatrists had vehicles it would be possible to arrange such conferences more regularly and frequently, and they could keep in closer touch with battalion aid surgeons. Such steps would help morale and improve the handling of psychiatric problems at the vital forward levels.

The morale of medical personnel assigned to psychiatric installations might be aided considerably if it were feasible, through civilian groups or otherwise, to cultivate and sustain their psychiatric interests through assurances of the possibilities for further training and future careers.

SUGGESTIONS FOR FURTHER STUDIES OF COMBAT EXHAUSTION

CLINICAL STUDY AT BATTALION AID STATIONS. Certain simple but important facts could be learned only by direct observation at the battalion aid stations. For the purpose of such a special study information on the following points is needed:

(1) The chief presenting complaints and symptoms and their relative frequency.

(2) The proportion of the men returned to fighting either at once or after one night's rest.

(3) The proportion of those returning promptly to duty who soon thereafter break down.

PROPHYLACTIC MEDICATION. We suggest a trial study of quick acting, non-cumulative barbiturate drugs (e.g. seconal) to learn their value in reducing the anxiety of men in combat. It has been claimed that small amounts of these drugs used in this way have no untoward effects on vigilance of endurance.

RESIDUAL CONDITIONS IN ZONE OF INTERIOR. Additional clinical studies of some of the residual symptoms and syndromes as seen in the general hospitals in the Zone of the Interior would gain in value when done by psychiatrists familiar with the earlier phases seen in the theater of operations.

PSYCHOLOGICAL TESTING. Psychological tests by very carefully selected psychologists of competence and experience should be made of a representative number of combat exhaustion cases at all available levels and various stages. These tests should include a complete battery of tests useful in personality study.

CONFERENCE ON SOCIAL FORCES IN THERAPY. The outstanding advantages of group therapy and the many evidences that the prevailing attitudes of a treatment center can make or mar its success lead us to recommend the thorough and systematic study and utilization of social forces in therapy. These extend much further than direct symptom-relieving suggestions. This study should include the emotional needs and satisfaction of professional staff and enlisted personnel, and the methods of developing and maintaining an optimal therapeutic atmosphere. We do not merely stress the importance of this therapeutic atmosphere and urge its cultivation, but we specifically emphasize the need for gathering detailed knowledge about it and for developing systematic insight into its modes of operation. As a practical first step we suggest a conference of a few selected army

psychiatrists, experienced in the management of group therapy and in the control of group attitudes, with one or two civilian consultants who have the qualifications for a cooperative study of this field.

VULNERABILITY. To get information regarding vulnerability to combat exhaustion, comparative data should be obtained on men who do not "break" but who are platoonmates of those who do so, and who have experienced the same stresses. This matter could be studied in a large unit which is to be committed to battle, by making a survey of a sample, appropriately selected, of officers and enlisted personnel of various age levels and from various cultural, economic and racial groups. This would make possible a comparison, unit by unit, so as to take into account the influence of such situational variables as:

(1) Nature, severity and duration of fighting ;
(2) Terrain and weather;
(3) Leadership and deaths of critical figures in the group;
(4) Quality, quantity and method of reinforcements.

Such a pre-combat survey would have to be carried out by a special team of psychiatrists, clinical psychologists and social workers. The data should include:

(1) A psychiatric evaluation of the personality;
(2) A brief battery of relevant personality and psychometric tests;
(3) A review of family background, and of the adjustment to home, school work, community, marriage and sex;
(4) A summary of previous combat experience and performance;
(5) A study of the personal relationships within sample squads or platoons.

R E C O M M E N D A T I O N S

ROTATION OUT OF COMBAT FOR REST PERIODS . . . . . .

REPLACEMENTS . . . . . .

OFFICER SELECTION. . . . . .

USE OF ABREACTION . . . . . .

OCCUPATIONAL THERAPY . . . . . .

SUPPLEMENTARY PSYCHIATRISTS . . . . . .

CLASSIFICATION AND NOMENCLATURE . . . . . .

PSYCHIATRIC ASPECTS OF MEDICAL AND SURGICAL CASES . .

STATUS OF SENIOR CONSULTANT IN PSYCHIATRY . . . . . .

R E C O M M E N D A T I O N S

ROTATION OUT OF COMBAT FOR REST PERIODS. Since combat exhaustion has been one of the major categories of lost manpower, under the conditions prevailing during the fighting in the European Theater of Operations, plans for regular rest may be the most effective measure for conserving manpower. This principle cannot be disregarded by command without certain consequence. A great deal of judgement is required in making and altering the arrangements for rest periods and other details of recuperation, beyond our ability to prescribe, for it involves weighing the advantages of continuously pressing the enemy when he is at a disadvantage even at the probable risk of a certain increase in psychiatric casualties as of other casualties. Such decisions involve the same sort of judgement as is necessary in the expenditure or conservation of any other military assets, whereby a present sacrifice may ensure a future advantage, but in this balancing there should be considered seriously the limitations of the physical and emotional endurance of men and those losses of group spirit and group effectiveness which result from tremendous casualties and unassimilated replacements.

As a further measure of preventive psychiatry, the Commission recommends that a definite number of combat days be established as the maximal service for the infantry rifleman, after which he should be transferred from combat duty for a period of several months.

Command policy cannot entirely prevent combat exhaustion but it can greatly reduce its incidence.

REPLACEMENTS. As a measure of preventive psychiatry in the process of reinforcement, we believe that, except in unforeseen emergencies, fresh reinforcements when sent up to forces in combat should not be sent individually (except they be men returning to their own units) but should be sent up as preformed units, certainly not smaller than squads, who have received at least some days of training as a unit, under the leader who is to go up with them, in the methods of warfare being used at that front, with the weapons to be used, and under conditions closely resembling those under which they are to fight. These considerations are exceedingly important in developing a familiar pattern of group action and in integrating the individuals effectively into a fighting team.

Moreover, the crucial psychiatric importance of trusted leadership and group integration implies that, so far as is feasible, the whole system of replacement depots should follow the principle of

training men in small units under junior officers and non-commissioned officers from training centers or brought back from combat experience for this purpose. We also consider it valuable, for the same purposes, to use whatever opportunity is available, when replacements go to a division, to indoctrinate them with something of the history, prestige, symbols and traditions of the division and to foster faith in its leadership.

OFFICER SELECTION. The Commission commend for consideration the manner in which psychiatrists and clinical psychologists are used in the process by which candidates are selected for the Officer Cadet Training Units (O.C.T.U.) in the British Army.

USE OF ABREACTION. We suggest that the use of chemical means for inducing or facilitating so-called "abreaction" in those patients requiring such aids be restricted to psychiatrists who have received the training and demonstrated the capacity to deal constructively with the psychotherapeutic issues concerned therein, or those physicians who work immediately under the supervision of such competent psychiatrists. Battalion surgeons and other physicians should be informed, by films or in special courses of instruction, regarding the opportunities and methods of giving psychotherapeutic aid to men who spontaneously wish to discuss some intense emotional experience.

OCCUPATIONAL THERAPY. A greater emphasis and importance might be placed on forms of treatment which relate to the employment and direction of energy, and the satisfaction of conscious and unconscious needs in the direction of constructive achievement, social cooperation, and organized group and individual functioning. These are to be found in the modalities labelled "Occupational Therapy, Recreational Therapy, Group Social Therapy", etc., providing they are administered by trained personnel, and accorded a place of dignity and importance on the prescribed schedule of the patients' activities, and providing they are supervised by physicians (psychiatrists) genuinely acquainted with their value. These forms of therapy are definitely distinguishable from the use of recreation, instruction and manual training in "Re-sec" units where the emphasized objective is return to duty rather than return to health. The use of these methods is commendable here, too, but this special recommendation of the Commission refers to intramural hospital therapy. Inasmuch as the Commission observed and heard complaints from patients regarding idleness and boredom in at least one representative and well-staffed exhaustion center, it would recommend the consideration of plans for a certain amount of organized therapy of these sorts as far forward as the army level.

SUPPLEMENTARY PSYCHIATRISTS. The Commission suggests that consideration be given to devices of military organization which would provide for the assignment of supplementary psychiatrists in the clearing stations and/or exhaustion centers at those times when either installation receives patients in such numbers that the staff is unable to handle them properly or effectively. Whether such supplementary aid should consist of one psychiatrist or comprise an organized mobile psychotherapeutic unit with one or more psychiatrists, wardmen and clinical help, equipment, etc., is a matter on which the Commission does not feel competent to offer a recommendation.

CLASSIFICATION AND NOMENCLATURE. The use of the term "Combat Exhaustion" should be continued as a tentative and inclusive first aid diagnosis. Its use should be limited to the zone of operations and the zone of communications. When a definitive diagnosis has to be decided upon, before the patient leaves the zone of communications, and as far as is feasible, in all cases discharged from hospital or exhaustion center, each case record should contain, in addition to the definitive diagnosis, a brief diagnostic formulation covering five points, as indicated in more specific form at the end of the discussion on Classification and Nomenclature, namely:

(1) Present clinical picture
(2) Situational influences
(3) Personality
(4) Degree of disability and expected duration, and
(5) Recommendations

The term "morbid resentment state" is suggested to designate a group of patients not properly classifiable under existing diagnostic categories. (See section on Classification and Nomenclature and on Clinical Evolution.)

PSYCHIATRIC ASPECTS OF MEDICAL AND SURGICAL CASES. Efforts might be made to further the utilization of psychiatry in Army medical and surgical practice in the evaluation and treatment of the so-called psychosomatic cases on the medical wards and in the study of convalescence on the surgical wards with an eye to the prevention of neurotic reactions in relation to wounds, mutilations and plastic surgery. The efforts we have in mind are designed to develop a more effective rapproachement between psychiatry and medicine and between psychiatry and surgery than the traditional modes of consultation. They include more active participation both by psychiatrists and by those requesting consultations so that the work becomes more of a joint effort. This implies that the psychiatrist assist and instruct the ward officer in taking pertinent

social histories, in personality evaluations and in treatment. We do not urge this as a universal practice, because there are not enough psychiatrists available, but rather we recommend a trial project in one or two hospitals.

STATUS OF SENIOR CONSULTANT IN PSYCHIATRY. Considering the magnitude and importance of the special psychiatric problems of the military forces in the E.T.O. appreciating the delicacy and complexity of psychiatric implications of command functions which require for their best management frequent and direct contact between line officers and psychiatrists, and appreciating also the influence of military status in such contacts, we suggest that the position of Senior Consultant in Psychiatry be placed on a par with the positions of the Senior Consultants in Medicine and in Surgery in the Office of the Chief Surgeon, as illustrated by the excellent example in the Office of The Surgeon General in Washington. This suggestion implies no criticism or disparagement of the Senior Consultant in Medicine, under whom the Senior Consultant in Neuropsychiatry now operates, and who, we believe, has given full cooperation and support. We merely mean to indicate, in general, the desirability of bringing the psychiatrist most directly and authoritatively into contact with the officers whose decisions are crucially important in relation to psychiatric problems, particularly the prevention of combat exhaustion.

APPENDIX - A

I T I N E R A R Y

The Commission left Washington by air at 11 a.m., 20 April 1945, and arrived 25 hours later at Paris, 6:30 p.m. Paris time, on Saturday 21 April 1945. Billeting, finance and other arrangements were made at Headquarters on Avenue Kleber. Billeting was at the 108th General Hospital (Hospital Beaujon, said to be the finest hospital in France) where we were hospitably received.

22 April was spent in part in visiting the psychiatric ward of the 108th General Hospital with Captain George L. Perkins, psychiatrist. The Commission then went to the Office of The Chief Surgeon on Avenue Kleber and called on the Executive Officer, Col. Howard Doane, and presented him with copies of our orders. Col. Doane advised us we would be able to see Major General Hawley the following day. We then attended a cocktail party given by Col. Lloyd Thompson and met Colonels Schnick, Everts, Salisbury, Klingman, and Peet who were members of the I. G. Commission which had just returned from the front. We also met Colonel Ernest Parsons and Colonel Rex Dively.

23 April 1945. Paris.

To General Headquarters on Avenue Kleber for a conference with Chief Surgeon Paul R. Hawley and his deputies, Colonels David E. Linton and Charles F. Shook. The Commission then called upon Mr. Bennet Archambault of the OSRD. The rest of this day was spent in the procurement of equipment and a long planning conference with Colonel Parsons.

24 April 1945. Paris.

The Commission visited the medical school of the University of Paris and was kindly received by Dean Baudoin. A long discussion on medical education in general and psychiatric education in particular ensued. The Commission was impressed by the fact that this medical school undertakes the training of 5,000 students in peace time and 2,000 at present, nearly half of whom are women. During the Occupation, the Germans took over the hospitals but the school continued. A considerable conversation was held with a French physician who had been a German prisoner for nearly five years and had only recently returned.

25 April 1945. Paris to Verdun.

Accompanied and escorted by Col. Ernest Parsons, the Commission left Paris early in the morning in two reconnaissance command cars. Previous conferences had indicated that in view of the fluid front, definite plans for the route be deferred until further forward. The line of travel extended east through Chateau Thierry, Epernay and Rheins, reaching Verdun by nightfall, after which travel was forbidden. The Commission was received at mess by the officers of the 99th General Hospital and a visit was made to the Psychiatric Ward with Major Ellis Bonnell and Captain Bernstein. It was here that we were first impressed with the usefullness of cheerful and solicitous medical wardmen, a point emphasized by these officers more than by some others. From the 99th we returned to the Hotel Vaubon where a very helpful conference was held with the Chief Surgeon of the 12th Army Group, Col. A. L. Corbey, on the basis of whose advice the rest of the trip was planned.

26 April, 1945.

Leaving Verdun before eight o'clock, the route was changed to lead through Arlons and Bastogne to Liege, where we had dinner at the 56th General Hospital, as the guests of Lt. Col. E. N. Wakeman, C. O., Lt. Col. B. H. Rutledge in charge of Medicine, Lt. Col. S. W. Moore in charge of surgery, Major H. A. Grennan, Assistant in Medicine, and Medical Administrator Captain Ottinger.

After dinner the Commission made a short stop at the 76th General Hospital in Liege - a tent hospital.

The night was spent at the 32nd General Hospital in Aachen, Germany, the staff being an Indianapolis Unit headed by Col. Cy Clark. Here we also met Major Stickle (Psychiatrist) Captain Rossman and others.

27 April, 1945. Aachen to Muchster.

Before leaving Aachen a brief visit was made to the hospital wards and one combat exhaustion case which had just arrived was seen.

Leaving shortly afterward, we visited a repatriation camp for 12,000 displaced persons not far from Aachen. We then made 275 hard miles through poorly mapped country (the Ruhr).

We stopped for lunch at the 85th Field Hospital at Puetzchen; meeting Major Zoll, C. O., Capt. S. R. Comb of Indianapolis and others. Here there had just been admitted over one hundred cases of accidental methyl alcohol poisoning in Russian refugees, quite a few of whom had died, some of whom were blind and nearly all of whom were acutely ill. We studied these cases briefly and discussed the general nature of the syndrome with the medical officers.

We billeted that night at the 48th Field Hospital at Muenster, Germany. Here the personnel was as follows: Major John R. Hill, C. O., of Columbia, Missouri, Capt. George Coe of Kentucky, Capt. L. C. Olsen of Wisconsin and attached officers from the 5th Auxiliary Surgical Group consisting of Major P. A. Reitz of Texas, Capt. Clyde Musselman of Lancaster, Pennsylvania, Capt. Ernest Craig of El Paso, and Capt. John C. Mitchell of Salina. We were impressed here with the fine spirit of these homesick, weary doctors; weather very cold and unpleasant.

28 April 1945. Muenster to Braunschweig.

After a particularly hospitable breakfast, we left early and drove 170 miles, mostly northeast, much of the way on the Reichsautobahn, through the province of Hanover to the city of Braunschweig, arriving at 3 p.m. We were hospitably received by the Chief Surgeon of the 9th Army, Colonel William Shambora and the Ninth Army psychiatrist, Lt. Col. Roscoe Cavell. Long conferences were held with both. Our billeting was in a recently vacated apartment house. The 9th Army Headquarters was located in the former Headquarters of the Luftwaffe.

29 April 1945.

Immediately after breakfast we set out for a portion of the front selected the previous day in conference with the Colonels mentioned and chief of operations, Col. Herman Reinstein. We stopped first at the 20th Field Hospital, Halberstadt, then filled with 1100 liberated political prisoners from a German prison camp about five miles away. (Langenstein?) They had been moved to this hospital about ten days previously; hundreds had died, many were moribund, many tuberculous, all emaciated. Their pallor and edema particularly impressed us. Lt. Col. C. S. Wilson was in charge here. After lunch we moved on toward the front.

We spent the afternoon at the 309th Medical Battalion of the 83rd division, near Calbe; with Lt. Col. Clovfelten, division surgeon, Major Alan W. Byrnes, the division psychiatrist, Major P. S. Mercuri, Bn. Executive Officer, Major H. T. Randall, Clearing Co. Commander 308th Med. Bn. of the

83rd Division and Lt. Col. Robert S. Higdon, C. O. of same. Here we saw a number of recently acute cases at some length and interviewed them. After dinner a three hour conference was held with Cavell, Byrnes, and others, discussing their experiences.

30 April 1945. Calbe to Braunschweig.

Leaving early in the morning we returned to Braunschweig via Magdeburg (passing within a few miles of the German lines). After getting the appropriate permission from the various authorities, a guide from the Military Government, and the escort of one of the medical officers of the army, we went to the Luftwaffe Lazarett, a hospital of 800 beds, largely intact! (One of our own medical officers who had visited over 100 German hospitals told us later that this was by far the best German hospital he had seen!) We were met by Mr. Karl Laryen, a male welfare worker (social worker?) and interpreter, who took us to the C. O. General Ludwig Harriehausen (in civil life a pediatrician from Breslau) who called in the neurologist, Dr. Albert Kentenich (Dusseldorf) and the psychiatrist, Dr. Nikolaus Wegschneider (Berlin) and (later) the chief internist Dr. Arthur Jores of Rostock. Dr. Jores in particular impressed us as an excellent physician. We were shown a number of patients, some excellent X-ray physiotherapy and low pressure-chamber equipment. Some general problems of aviation psychiatry were discussed and a few patients were questioned.

Conference in quarters in the evening.

During the evening conference the son-in-law of one of the members of the Commission (K.A.M.) Lt. William Nichols, arrived from an outlying post. Lt. Nichols had seen many months of active combat as a squad leader and infantryman and gave much pertinent information regarding the attitude of the men in the ranks and the non-medical officers toward the problem of combat exhaustion. Lt. Nichols remained overnight and conferred with us further the following morning before returning to his post.

1 May 1945.

At the request of Lt. Col. Roscoe, Cavell, the division psychiatrists from the 9th Army assembled this day for an all day conference. Those present were as follows:

Major A. V. Stabile 79th Inf. Division	Home Address: Syracuse, New York
Major Wm. Furst 75th Inf. Division	Home Address: Newark, N. J.
Major Leonard C. Lang 100th Evacuation Hospital (DS at Ninth Army Exhaustion Center)	Home Address: Buffalo, New York
Major Hiron Miller 2nd Armd. Division	Home Address: Providence, R. I.
Major Vivion F. Lowell 30th Inf. Division	Home Address: Quincy, Illinois
Major David I. Weintrob 29th Inf. Division	Home Town: Brooklyn, New York
Major Nathan H. Root 8th Armd. Division	Home Town: New York City
Major Edward S. Tauber 102nd Inf. Division	Home Town: New York City
Major Lazarus Secunda 5th Armored Division	Home Town: Boston, Massachusetts
Major Allen W. Byrnes 83rd Inf. Division	Home Town: Fraer, Iowa Perm. Addr. Richland, Mich.
Major Harry H. Schwarts 35th Inf. Division	
Major Richard H. Parks 84th Inf. Division	Home Town: Hattiesburg, Mississippi
Captain Conrad A. Loehner 113th Evacuation Hospital	Home Town: Los Angles, California
Captain Richard C. Cooke 111th Evacuation Hospital (DS at Ninth Army Combat Exhaustion Center)	Home Address: Boston, Mass.
Captain J. C. Tedesco 95th Inf. Division	Home Town: Arcade, New York

Major Teuber spoke in detail of his impressions of a German psychiatric hospital he had visited and the therapeutic methods used by the Germans. Major Lowell, who had visited over 100 German hospitals, spoke of these generally. Major Stokes described three common types of acute psychiatric combat reactions.... the jittery, the played out, the war weary. Blast syndrome was discussed by several officers. Major Stabile gave a vivid and moving account of the experiences of men, officers and medical detachments in acute, severe, and long continued combat. Major Weinbrodt emphasized and illustrated the reciprocal relationship between neurotic breakdowns and disciplinary problems. (AWOL) especially, as influenced by command attitude.

Toughness versus tenderness in battalion surgeons was discussed. Such problems as guilt feeling from shooting young Germans, from bayonetting, from "soldiering" and hanging back, from shooting prisoners, etc., were discussed. Major Rost and Major Miller talked about the special features of armored units in combat, the lesser frequency and different types of psychiatric sequellae and reasons therefore, and other matters. Major Secunda spoke at length and clearly on the importance in the prevention of combat exhaustion of

(a) definite limited missions and

(b) leaders who convince their men of a personal interest in them, and

(c) leaders who keep their men informed

In addition to these mentioned, there were many descriptions and discussions of acute combat reactions and other psychiatric problems of Army life and activity. The earnestness, patience, and weariness of these fine men impressed the Commission very much.

2 May 1945. Braunschweig to Weimar.

After official goodbyes were said, the Commission departed Braunschweig for Weimer, 150 miles South, passing through the Harts mountains and the cities of Harzburg and Nordhausen. In places the ground was lightly covered with snow, and in many places evidences of recent fighting. We arrived at 1st Army Headquarters at Weimar about 4 p.m. and were sent to the 622nd Clearing Company which was functioning as an Exhaustion Center. This was housed in one of three huge concrete buildings which the Nazis had intended to use as the Headquarters for the new Government, but had not quite completed.

The officers here were as follows:

Army Surgeon: (on leave)	Brig. Gen. John Rogers
Assistant Surgeon:	Col. James Snyder
Executive Officer:	Col. Murphy
Army Psychiatrist:	Lt. Col. William Shrodes
Army Consultant in Medicine:	Lt. Col. Neal Crone
Clearing Station Staff:	Inspector Gen. representative:
C. O. Major Joseph MacMahon	Colonel Touze
Clinical Director:	Major Harry G. Rainey
Assistants:	Captain Bernard Ratner
	Captain Everett Lombard

Other Medical personnel:
Captains Otto Rath, Julian Stamm, Jack Kahn, Ralph Cotter and Charles Single.

3 May 1945. 622nd Exhaustion Center and Buchenwald.

The morning was spent in studying cases presented by Major Rainey and staff, including an acute combat exhaustion and another type of psychiatric illness occurring in a man with numerous decorations and a long period of very active fighting.

In the afternoon the Commission was taken to visit Buchenwald Concentration Camp, about 6 miles out of Weimar, and were escorted through the recently liberated prison by a former prisoner, who was a physician who stated that in his earlier years he had worked and taught at Harvard Medical School, and knew Morton S. Prince, Southard, etc. We saw some cases of typhus here and, of course, many starvation cases.

4 May 1945.

The forenoon was devoted to the personal interviewing of patients by the separate members of the Commission. The afternoon was occupied by a meeting of the division psychiatrists of the 1st Army. A list of those present:

Major Philip Wagner
45th Evac. Hospital
APO 230

Major Theodore J. Dulin
9th Armored Division
APO 259
Home Address:
4252 N. Kedvale Ave.
Chicago, Illinois

Major Harry C. Rainey
622nd Clearing Station
1st Army, APO 230

Major Adio A. Friedman 87th Infantry Division APO 87	Home Address: 5816 Kenmore Avenue Chicago, Illinois
Major William T. Mac Lauchlin 9th Infantry Division APO 9	Home address not given.
Major Richard F. Richie 69th Infantry Division APO 69	Home Address: Boalsburg, Pennsylvania.
Major Benjamin Wiesil 76th Infantry Division APO 76	Home Address: 124th E. 81st St New York
Captain Everette P. Lombard 67th Evacuation Hospital APO 230	Home Address: Short Falls, N. H.
Captain Peter A. Martin 104th Infantry Division APO 104	Home Address:
Captain Otto H. Raths 622nd Medical Clearing Co. (Sep) APO 230	Home Address: 1171 Summit Avenue, St. Paul, Minn.
Captain Bernard Rattner 97th Evacuation Hospital APO 230	Home Address: 4137 North Troy Street Chicago, Illinois

In the evening the Commission learned much from a long conference with chief Medical Consultant Col. Crone.

5 May 1945.

The examination of patients by members of the Commission separately had proved so valuable that it was continued on this day.

In the afternoon the Commission called on Col. James Snyder, the Assistant Surgeon of the 1st Army, who received us in the absence of the General Surgeon Brig. Gen. John Rogers.

In the evening a conference was held with some comparison of findings and impressions.

6 May 1945. Weimer to Erlangen.

Although the Commission had wished and planned to remain longer at the 622nd, the order to move the hospital made it necessary to proceed on our way and so we went south another 150 miles to Erlangen, Headquarters of the 3rd Army.

Chief Surgeon:	Colonel Hartford
Internal Medicine:	Lt. Col. Weil
Psychiatry:	Lt. Col. Perry J. Talkington

After official greetings, registration, etc., we went for billeting to the 106th Evacuation Hospital, Col. Ralph Thompson (Omaha) in charge and Major Herold Christiensen (Minnesota) Psychiatrist, Lt. Col. Willis Jacobus (Kansas) Surgery. We were treated with particularly fine hospitality here. Major Christiensen discussed his experiences with us.

7 May 1945. Erlangen to Regen.

The Commission proceeded on through nearby Nuremberg and all were appalled at the completeness of the destruction of this city. We continued south and east through Regensburg and Straubing, lunching at Regensburg, General Patton's Headquarters. We had supper at Grafenau, the Headquarters of the 12th Corps. Here Col. D. V. MacCallum (APO 312) was the Corps Surgeon.

For night billeting we returned to the 106th Evacuation Hospital Regen, on the banks of a mountain stream from which woods arose on one side and hills on the other, making it a beautiful tent hospital site. (In the course of reconnaissance for it, our companion of the C. O. had been killed by strafing planes). Col. J. D. Hancock (C. O.) of Louisville, and his staff (especially Capt. O. R. Timm and Major E. W. Mericle of the 4th Armored) entertained us with an excellent dinner and a social visit afterwards. Captain Timm told us about his methods of treatment and results. The excellent plan of the NP tent hospital set up was studied, and a plan of it drawn and given to us by Colonel Hancock.

8 May 1945. Regen to Titling.

After an excellent breakfast the Commission was conducted by some young M.A.C. officers into Czechoslovakia, where we were met by crowds of cheering, beaming, waving Czechs, many in holiday costumes. We stopped at Susice (formerly called also Shuettenhofen) and met Major E. F. Beshore of Athens, Ohio, psychiatrist, and Lt. Col. Gaylord Andre, surgeon, and

Captain Joseph D. Karras, all of the 90th Infantry. The excitement of the announced peace and the complete cessation of fighting made clinical investigations here impossible, so we drove on further into Czechoslovakia to Kasperske Hory, where a Regimental Aid Station 358 (actually combined with battalion aid) was manned by Capt. R. H. Bulger and housed in the former Bar of the Fux Hotel. Captain Bulger discussed his experiences, techniques, impressions and observations to us at length. (A short interruption in the conference was made to hear Churchill's peace announcement). While the conference was in session, many German prisoners were being brought past the station in trucks and cars, including a three star general whose name was not learned.

Following this conference we returned to Bavaria, taking supper with the 5th Infantry Division near Fruyling, where we met Lt. Col. Enos G. Walker, Division Surgeon, and Major Harry Nesmith, Psychiatrist. After supper we travelled on to the 110th Evacuation Hospital near Titling. (Adjoining it was a camp of 8000 German prisoners with 4 M. P. guards and there was also some excitement over the shooting down of 2 German planes which had flown over AFTER the peace declaration). We did not meet the C.O. of the 110th — he was absent. We did meet Capt. Otto Bendheim (APO 403) an American physician born and reared in Germany, who described interesting reactions of a former German citizen to the present duties of an Army officer.

9 May 1945. Titling to Augsburg.

The Commission proceeded on into Austria and back into Germany, obstructed by numerous blown bridges and traffic jams, arriving at Miesbach by supper time; we were hospitably taken in by the 101st Airborne Division, 326th Airborne Medical Company (APO 472) and given a fine fried chicken supper. (This was the night that it was served generally in the Army, even to Goering, which the newspapers thought was a special favor to him). The members of the Commission enjoyed talking to these airborne medical men about the special features of parachute troop life and psychiatric reactions. The names of these officers were Captain K. A. Hammond and Captain L. D. Lide.

After supper we proceeded West, passing through the heart of Munich, a ruined city; to us the most impressive sights were the long lines of camouflaged planes, many of them undamaged, along the autobahn and the sinister road marker

just west of Munich which read DACHAU. (It was too late in the day for us to stop here, a fact which we later regretted all the more when we learned that it had only been captured a day or so previously and was still full of corpses and other consequences of crowding 40,000 people into a 6,000 man prison.)

War having officially terminated, we were permitted to drive at night and so drove on, arriving late at Augsburg, where we were billeted in comparative luxury at the Kaiserhof Hotel, where there was running water.

10 May 1945. Augsburg.

In many ways this was one of the most profitable days of our journey, because of the intelligence, competence and articulateness of Major A. O. Ludwig, chief psychiatrist to the 7th Army. (Colonel M. P. Rudolph is the C. O. at these Headquarters and was the only other medical officer we met). Major Ludwig spoke to us for 4 hours in the morning and 4 hours in the afternoon and several hours in the evening, giving us a summary of his experiences historically and analytically and answering many questions. All members of the commission took elaborate notes and were reluctant to say goodbye.

11 May 1945. En Route West. Augsburg, Germany to Luneville, France.

This was the hardest day of travelling for the Commission. The roads were disorganized, broken, crowded and dusty, the weather having turned warm. We proceeded through Wurtemburg, through Tebingen and Freudenstadt. Crossing the Rhine at Strasbourg, turning south in Alsace toward Colmar, then west again toward Nancy, ending a three hundred mile stretch at Luneville, France. We spent the night at the 51st Station Hospital, a former school for girls converted into what was supposed to be a neuro-psychiatric installation. For five months (since January) it had received few patients, however, and there was obviously stagnation of interest. At this time there were no patients at all for the 40 nurses and 30 medical officers to care for, and no officer recreation or educational program. We had some conversations with Major H. B. Paul, the psychiatrist; apparently this is one of two places where some hypnosis had been used.

12 May 1945. En Route North. (Luneville to Ciney, Belgium)

Heading generally North and East, we drove through France and Luxembourg into Belgium, arriving at Ciney in the late afternoon, where we went directly to the 130th General Hospital.

Here we remained a week, Colonel Parsons, our incomparable escort, departing for Paris.

The officers at the 130th were as follows:

C. O. Lt. Col. Howard Sweet	
Executive Officer:	Lt. Col. Paul Casey
Chief of Professional Services:	Lt. Col. Paul Lemkau
Chief Psychiatrist:	Major Douglas Kelley
Chief Surgeon:	Major Abrahamson
Chief Neurologist:	Major Howard Fabing
Captain Oscar Le Gault	

The Commission was entertained at a party at the Officer's Club on the night of their arrival and generously provided with excellent rooms, excellent mess, and many favors from the Officer's Club.

13 May 1945. Ciney, Belgium.

This first full day at the 130th began with a staff conference at which the history, the development and an outline of the structure of the unit was presented by Lt. Col. Casey and discussed by all members of the Staff and Commission. Later in the day the Commission was taken to the Red Cross Department to observe the patients' entertainment and interview the Red Cross Workers.

14 May 1945. Ciney, Belgium, third day.

The morning was spent in inspecting the Hospital and meeting other members of the staff. In the afternoon a case was presented which was discussed by and with all members of the staff and commission.

15 May 1945. Ciney, Belgium, fourth day.

In the forenoon Major Kelley presented the programme of the hospital rather fully, followed by a discussion of the "combat-exhaustion" syndrome.

In the afternoon the Commission visited the Rehabilitation Section of the Hospital (Resec) located in a Chateau and surrounding farm about a mile away from the Hospital, under Capt. Kelligan, MAC. Here the patients who had spent 30 days in the Hospital spent an additional 30 days in a programme of readaptation to army life, with drills, classes, target practice, lectures, recreation, and so forth. The Commission

walked around the obstacle course, then down to the Rifle Range, observed a class in manoeuvres, then visited classes in telegraph, motor car repair, radio, and so forth. All members of the Commission fired some army rifles, to get some impression of the experience. At 6 o'clock each evening a 'Sick Call' is conducted at the Hospital by Lt. Col. Lemkau and one member of the commission sat with him each evening to observe this. At this Sick Call soldiers who are not getting along well at 'Resec' are seen and, if it is thought necessary, readmitted to the hospital for further treatment.

16 May 1945. Ciney, Belgium, fifth day.

This entire day was spent with Major Howard Fabing who occupies a small detached building outside the main Hospital, where he treats cases of what has been called the 'Blast syndrome'. (Loss of consciousness following explosion, followed by prolonged headache, dizziness, tinnitus, diffuse anxiety symptoms, especially noise sensitiveness, with negative neurological examination).

Major Fabing has worked out a special method of treatment for these cases, combining sedation, abreaction, sudden awakening and recapitulation, which he demonstrated to us on two cases. He has also worked out a theory about these cases, which he expounded to us at length in the evening.

17 May 1945. Ciney, Belgium, sixth day.

Major Kelley demonstrated his technique of abreaction and group therapy who also discussed.

A number of patients were seen individually by individual members of the commission and the members of the commission conferred together about these cases later.

Lt. Col. M. M. Froelich, of the 298th General Hospital, (APO 228) located at Liege, Belgium, came over in the evening, partly for a conference with us and partly for a party given by the staff of the 130th in our honor.

18 May 1945. Ciney, Belgium, seventh day.

Most of the Commission went to Liege to visit the 298th General Hospital, where we compared the work done by Lt. Col. Froelich who used no abreaction, no sedation, but only psychotherapy.

One member of the Commission spent three mornings in the wards devoted to the combined use of Insulin and Narcosis.

19 May 1945. Ciney, Belgium, eighth and last day.

Col. Thompson, having arrived from Paris; the Commission had a conference with him regarding his impressions of the work of this hospital and of the Combat Exhaustion Syndrome. Col. Thompson felt that the Commission might now advantageously move on to Paris, so the final day was spent in personal interviews with patients and saying goodbye to the hospitable Hospital Staff.

20 May 1945. Ciney to Paris.

This day was spent chiefly in travelling through Dinant and the Meuse Valley, through Rheims and Soissons to Paris, arriving at the 108th General Hospital about 6 p.m.

21 May 1945. Paris. 108th General Hospital Again.

This entire day was spent in the personal investigation of individual cases of the neuro-psychiatric department by various members of the Commission, followed by a group conference to compare notes and impressions.

22 May 1945. Paris. 108th General.

The same programme as on the day before was continued. In the late afternoon during a group conference, we received orders to move immediately to the 217th General Hospital (La Pitie) adjoining the Salpetriere (on the left bank of the Seine).

23 May 1945. Paris. 217th General Hospital.

The afternoon was spent at the Hotel Prince de Gaulle, where a meeting of approximately 20 of the psychiatrist in the Paris area had been called by Col. Thompson. This involved a discussion of the experiences of the various men, their impressions and opinions of the psychiatric syndromes and treatment methods. It terminated, like the other meetings with the Army psychiatrists, in a discussion of opportunities for post-war, post-graduate education.

Those in attendance in addition to Col. Thompson and the Commission were as follows:

Major E. P. Boemer (Cornell) 1st Gen. Hosp.
Major P. B. Grimes, 48th Gen. Hosp.
Major E. O. Erikson, 36th Gen. Hosp.
Major Douglas Kelley, 130th Gen. Hosp.
Lt. Joseph Grassi, (psychologist) 203 Gen. (Paris)
Major J. H. Rankin, 217th Gen. Hosp. (Pittsburgh)
Captain Paul Dunstan, 365th Sta. Hosp.
Captain A. R. Hamel, 198th Gen. Hosp. (Paris)
Capt. R. E. Kennedy, formerly with 8th Div. now at 203rd Gen. Hosp.
Capt. George L. Perkins, 108th Gen. Hosp.
Capt. Russel W. Ramsey, 194th Gen. Hosp.
Major R. L. Swank, 191st Gen. Hosp.

Following the meeting some of the officers repaired to Col. Thompson's apartment to see the British film on Combat Exhaustion and some other military pictures.

24 May. 1945. Paris. 217th General Hospital.

The Commission was invited to attend the conference in the office of the Chief Medical Consultant of ETO, Col. William Middleton, at which reports were presented by the heads of the various departments.

Col. Thompson for the Department of Psychiatry reported that 80% of all NP cases seen in medical installations in ETOUSA had gone back to duty. Col. Thompson also reported on the follow-up study of 500 patients treated at and returned to duty from the 312th Gen: 80% of these were still on duty after six months.

Col. Middleton reported that 1 1/2 million patients had been treated in approximately 200 stationary and 100 mobile hospitals in ETO staffed by approximately 2200 medical officers.

Lt. Col. Badger, Col. Long, Col. Pillsbury, Col. Kneeland, Col. Ralph Muckenfuss, and Col. John Gordon gave reports on various medical topics.

Following this meeting a combined report of surgical and medical consultants was made to General Hawley on a conference to which the Commission was invited.

General Hawley entertained all the consultants and the Commission at a pleasant cocktail party at 5 o'clock, at which some British guests were also present, plus Col. Ossipov, of Russia.

25 May 1945. 108th General Hospital.

The first of a two-day Inter-Allied medical meeting presided over by Gen. Hawley began with a conference on the saving of medical man-power. British and American and Canadian systems were explained and compared.

The Commission took advantage of some spare time in the afternoon and evening to attend to some personal affairs and write some notes.

26 May 1945. 108th General Hospital.

The Inter-Allied medical meetings continued today in sections. The Commission attended a joint meeting of the British and American psychiatrists where presentations were made by Lt. Col. A. O. Ludwig, Col. Roscoe Cavell, Brig. General Rees, Lt. Col. Talkington and Dr. Bartemeier. Dr. Morris Saunders, an American physician, resident for many years in Paris and for a time a prisoner in a German War Camp was a guest.

In the afternoon the various members of the Commission went to various places for special investigations. One studied psychosomatic cases, one conferred with some psychologists, etc.

In the late afternoon Col. Lloyd Thompson entertained at tea and cocktails for the psychiatrists, who were also invited to attend a party given by the Third Army in another suite of the Hotel George V. attended by General Hawley and numerous British officers. This was followed by a very fine dinner at the same hotel and a theater party at the Casino de Paris.

27 May 1945.

The Commission used this as a day of rest, letter-writing, note completion and, in the afternoon attendance upon the Paris Grand Opera.

The evening was spent with Col. Thompson and an old friend of one of the members of the Commission, Col. Howard Searle of Topeka, Kansas, a member of the famous 7th Corps of the First Army. As a member of the General Staff, Colonel Searle was able to tell the Commission a great deal about the problems of psychiatry from the Army administrative standpoint.

28 May 1945. Paris.

The Commission met to plan the construction and writing of its report and then separated to make various individual investigations. One member studied the psychological aspect of hand injuries at the 217th General Hospital, one made another visit to the 108th General Hospital, etc. Some members revisted the Salpetriere Hospital and some members also met and conferred with a French civilian surgeon who had been for 4 1/2 years a German prisoner of war.

29 May 1945. Paris to London.

Arising early, the Commission left before 5 A.M. for the ATC Headquarters in the Place Vendome and from there to the airport where a plane to London landed at Bovington and the Commission was transported to London by bus.

After formal introduction to the Base Chief Surgeon, Brig. Gen. C. B. Spruit, the Commission proceeded to their billet at Bailey's Hotel, 140 Gloucester Road, S. W. 7.

30 May 1945. London.

A five hour conference was held at Medical Headquarters. The following officers represented the American Air Forces, whose headquarters are at High Wycombe, about 20 miles north of London.

Major Douglas Bond, APO 634
Major Howard Burchell (Internist, formerly Mayo Clinic)
Captain Albert Owers (2208 San Gabriel, Austin)
Captain Nicholas Camara-Peon (psychiatry)

These men are attached to the 1st Central Medical Establishment of the Air Forces. Major Bond is a member of the Central Medical Board of the 8th Air Corps.

They reported in detail regarding the 1800 psychiatric patients seen and in regard to the specific details of psychiatric phenomena observed in fliers and other aviation personnel. The Commission made many notes of a technical nature to be included in material cited elsewhere.

31 May 1945. Stafford, England. (312th General Hospital)
(Shugborough Park)

The Commission, accompanied by Col. Thompson, left early in the morning in a seven-passenger car and driver, heading northeast through St. Albans and Coventry to a private estate near the town of Stafford, England. This estate is known as Shugborough Park and is the property of Lord Lichfield. Here, the 312th General Hospital, APO 852, has been in operation under the direction of Lt. Col. Lewis H. Loeser. This is the hospital set up originally by Col. Parsons as a neurosis center. In recent weeks the patient flow has become less and less so that almost no patients were seen and as it happened there were almost no medical officers present on the day of our visit. Major Edward Greenwood, whom we had specially hoped to see, had just left for Paris on orders. The Commission all sat down in front of a cheerful grate fire and Col. Loeser explained clearly and fully the methods and experience of his unit. A tour of the hospital was made and attention called to the various features elsewhere recorded. After a very fine supper, the Commission left for a drive of approximately 50 miles to a point about as far south of Birmingham as the 312th is north of it, arriving at the 96th General Hospital at the foot of the Malvern Hills near Malvern (APO 121), about 8 P. M. We were entertained informally in the Officers' Club by the staff.

1 June 1945. Malvern and Oxford, England.

The medical men at the 96th General Hospital were as follows:

Colonel E. Montgomery Smith (C.O.)
Lt. Col. B. L. McCloud
Major R. G. Reed (Administration)
Lt. Col. Hugh E. Kiene
Major Walter Goldfarb (Neurologist)
Major Albert Rauw
Captain Harold Rosen
Captain Wm. Needles (psychoanalyst) (absent)
Lt. Col. Arthur O. Hacker (Consultant from 12th Hospital Center at Malvern)

The hospital had specialized in the care of the more severe psychiatric cases, chiefly psychotics.

The Commission was taken on a tour of the hospital, insulin treatment and electric shock treatment wards were visited and the treatments demonstrated; then the Commission met with the entire medical and nursing staff in the assembly room where Col. Kiene requested that we each make a few remarks. After a late lunch, the Commission started out again for London, passing through Broadway and Oxford, at both of which short stops were made.

2 June 1945. British Army Medical Department Headquarters.

This was the first of 13 days spent as guests of the British Government, mostly in the Army Medical Department, but including a visit to Navy and Air Force installations. The courtesy, hospitality, thoughtfulness and thoroughness of these arrangements cannot be overstated. Cars with drivers were sent to our hotel every morning to take us to the appointed places and we were each provided not only with a carefully specified itinerary and directory, but with a bound portfolio of documents relating to the work and installations to be seen or described, or both.

On this first day we were taken to Hq., Royal Army Medical Department, 39 Hyde Park Gate, S. W. 7 where in the conference room, around a large table, we sat with the command Psychiatrists and the administrative staff. For purposes of military administration the U. K. is divided into seven commands in each of which there is a Command Psychiatrist responsible for coordinating and supervising the psychiatric work done by means of a variable number of area psychiatrists. Every two months a Command Psychiatrists Conference is held at the War Office (alternating with area Psychiatrists meetings in each command). The first command meeting was held in May 1940 and the one attended by us was the 31st such meeting. Those present at the meeting as recorded in the official minutes of the British War Department were as follows:

PRESENT:

Brigadier I. A. Sandiferd, M. C.	Directory of Army Psychiatry (in the chair)
Brigadier J. R. Rees	Consulting Psychiatrist to the Army
Brigadier G. B. James, M. C.	Consulting Psychiatrist to the Army at home.
Lt. Col. R. F. Barbour	Adv. in Psychiatry, 45 Div.
Lt. Col. D. Carroll	Cmd. Psych. Northern Cmd.
Lt. Col. N. Copeland	A.D.A. Psych. (A) A.M.D. 11.

Lt. Col. C. R. Hargreaves	A.D.A. Psych. (O) A.M.D. 11.
Lt. Col. S. A. MacKeith	Cmd. Psych. Southern Cmd.
Lt. Col. A. Torrie	Cmd. Psych. London Dist.
Major C. C. Beresford	Cmd. Psych. Western Cmd.
Major J. Gilroy	Cmd. Psych. Scottish Cmd.
Major J. Milne	D.A.D.A. Psych. (B) A.M.D. 11.
Major F. Pilkington	D.A.D.A. Psych. (C) A.M.D. 11.
Captain C. Bard	A/Cmd. Psych. H. Ireland.

In Attendance

Dr. Leo H. Bartemeier)	
Dr. Lawrence S. Kubie)	Scientific Consultants
Dr. Karl A. Menninger)	to U. S. War Department
Dr. John Romano)	
Dr. John C. Whitehorn)	
Brigadier A. D. Buchanan Smith	D. S. P.
Brigadier W. Stephenson	Consulting Psychologist to the Army
Colonel Lloyd J. Thompson	Consulting Psychiatrist, ETO, U. S. Army
Lt. Col. H. B. Craigie	O. C. Bellsdyke, Military Hospital
Lt. Col. D. McMahon	S. P. 3
Lt. Col. J. D. Sutherland	Senior Psych. W. O, S. Hs.
Lt. Col. I. Sutton	O. I. C. Division, Worthfield
Lt. Col. A. T. Wilson	Psychiatrist, Civil Resettlement Planning H. C.
Major D. Kelly	U. S. Army, U. K. Base
Major C. C. Prothero	P. S. O. att. D.G.A.M.S.

It was a great advantage to the Commission to attend this meeting, as it afforded us an excellent introduction to subsequent experiences and contacts.

The Commission was particularly impressed with the similarity, one might almost say the identical nature, of the British Army psychiatric problem and the American Army psychiatric problems. At noon the members of the Commission were taken as guests to the famous old Royal Army Medical College Officer's mess at Millbank. We were welcomed by the Commanding Officer, Col. F. S. Irvine. Late in the afternoon, when the meeting had ajourned, two members of the commission went with Brigadier J. R. Rees to his country home and three others took the train for the country home of Dr. W. S. Maclay. This opportunity for quiet visits in the country homes of distinguished British psychiatrists and for seeing the English countryside, customs, etc., was greatly enjoyed, and as a matter of background was valuable to us.

4 June 1945.

The British psychiatrists had arranged for us on this day a program presenting in summary form some of the work of the army's psychiatric Department.

The program was as follows:

Personality Study in Cases of Organic Disease and Disablement.
by Major Eric Wittkower
Technical Developments in Officer Selection Methods
by Lt. Col. J. D. Sutherland
Some Advantages of Group Interviews by Major W. R. Bion
The Study and Therapy of the Group by Lt. Col. T. F. Main
Psychological Problems of the Repatriated Prisoner of War
by Lt. Col. A. T. M. Wilson
The Study of German Psychology by Lt. Col. H. V. Dicks
Two films sponsored by the Directorate of Army Psychiatry at Curzon Cinema, Curzon Street, W. 1.

(a) "Field Psychiatry for the Medical Officer"
A psychiatric training film for Regimental Medical Officers.

(b) "The New Lot"
A psychological orientation film for recruits.

In the evening a party was given for the Commission and the available British Psychiatrist at the London flat of Brigadier Rees.

5 June 1945.

The Commission was taken by auto to Hatfield, an old town about 20 miles north of London to visit the Civil Resettlement Planning Headquarters and Unit No. 1. This is a plan to deal with thousands of repatriated war prisoners now returning to England from Germany, whereby those who elect it are given 30 days with pay, under the care of special units who plan a program for their rehabilitation. This headquarters and unit are located at the famous old Hatfield Palace and Hatfield House, the former of historic interest and the latter typical of the old great Manor Houses. It is the seat of Lord Salisbury.

The Director, Col. R. M. Rendel, the senior medical officer (psychiatrist) Lt. Col. A. T. M. Wilson, the senior psychologist Lt. Col. E. L. Trist and the civil liaison officer, Chief Commander J. Boyle, plus the Director of Unit No. 1 Col. Cholmondley, Lt. Col. Dawson and Major M. I. Silverton,

entertained the Commission at lunch, conducted them through the palace and Hatfield House (unit and headquarters buildings) and discussed with them the technique and plans of the project.

It is calculated that about 80,000 men are eligible for care in these institutions which can take about 250 men at a time. 80% are electing to accept at the present. They may stay any length of time from one day to several months, but usually they stay four weeks. They make visits to factories, they see some of the old movie films which were shown while they were in prison and they receive any civilian visitors. The officers feel that it does something to help diminish hostile feelings against the Army and hence it is to the Army's interest to further the project.

The Commission returned early from this visit in order to prepare for their appearance at 5 p.m. before the Section on Psychiatry of the Royal Society of Medicine at 1 Wimpole Street. This was a special meeting called to hear the five members of the Commission present brief discussions on the following topics:

Recent Civilian Experience in the Rehabilitation of Veterans with Psychiatric Disorders	Leo H. Bartemeier
Induced Dissociations in Psychotherapy	Lawrence S. Kubie
Trends in Medical Education	Karl A. Menninger
Studies of Syncope	John Romano
Constructive Factors of Personality	John C. Whitehorn

Following this meeting, the Commission was entertained by Dr. R. D. Gillespie and staff at Guy's Hospital and the York Clinic.

6 June 1945. Northfield.

Escorted by Brigadier Rees and Lt. Col. Hargreaves, the Commission left at nine o'clock for Birmingham, arriving at noon, and were driven immediately to what was formerly a mental hospital on the outskirts of the town. It is now known as Northfield, and is used as a Neurosis Center, comparable to the 312th U. S. General Hospital at Stafford, or the 130th at Ciney. This hospital accommodates 800 patients and makes a special point of integrating with its more

specific psychiatric treatment various forms of group psycho-therapy, psycho-drama, occupational therapy, recreation, education and part-time civil employment, under the term "social therapy." This is undertaken chiefly by autonomous groups of patients. This interesting plan of treatment has been introduced into as many hospital affairs as possible, and was demonstrated fully to the Commission. A program of the two days spent here will indicate the general nature of this work, and the carefulness with which the visit was planned. The program was carried out as indicated.

Northfield Military Hospital. 6 June 1945.

1230 Lunch

1330 In the lecture room: Introductory Conference Clinical Material and Policy - Lt. Col. I. Sutton, R.A.M.C.

Group Therapy — Major S. H. Foulkes, R.A.M.C.

Social Therapy — Major H. Bridger, R.A.

Clinical Proceedings — Captain M. C. Dewar, R.A.M.C.

1400 Visit to Continuous Narcosis Ward
Lt. Col. T. F. Main, R.A.M.C.

Visit to Art Hut — Sgt. I. Bradbury, R. E.

1500 In the lecture room: clinical demonstration.
Three cases with mourning reactions.
Lt. Col. T. F. Main, R.A.M.C.

1530 Group Therapy: A clinical demonstration.

Dr. L. H. Bartemeier	
Dr. Karl Menninger	with Capt. G. H. Day, R.A.M.C.
Dr. Lawrence Kubie	with Capt. M. C. Dewar
Dr. John Romano	with Capt. A. Essex, R.A.M.C.
Dr. John Whitehorn	
Lt. Col. C. R. Hargreaves	with Major S.H. Foulkes, R.A.M.C.

1630 Tea in the Ante-room

1715 In the lecture room

Enactment Therapy: a demonstration.
One case with Major S. H. Foulkes, R.A.M.C.
One group with Major H. Bridger, R.A., Major Foulkes, R.A.M.C. and Captain A. Essex, R.A.M.C.

1900 to 1930 dinner

2030 Paper: "Social Therapy". . . .Major H. Bridger, R.A.

2100 Visit to Hospital Club. .Captain G. H. Gray, R.A.M.C.

Thursday 7 June 1945.

0745 - 0830 Breakfast

0830 In the lecture room.

Paper: Group Therapy - Major S. H. Foulkes, R.A.M.C.

0915 In the lecture room

Demonstration: Sociograms, Lt. Col. T. F. Main, R.A.M.C.

0945 Ward Meetings: A demonstration

Dr. L. H. Bartemeier) with
Dr. Lawrence Kubie) Major S. H. Foulkes, R.A.M.C.

Dr. Karl Menninger) with
Dr. John Romano) Captain L. A. Collins, R.A.M.C.

Dr. John Whitehorn) with
Lt. Col. G. R. Hargreaves, R.A.M.C.) Captain M. C. Dewar, R.A.M.C.

1015 Coffee in the Ante-room.

1045 In the Hospital Club

Group Activities - A Demonstration
Major H. Bridger, R. A.

1140 In the Ante-room. Selected Postings.
Captain C. Routledge, R.A.S.C.

1200 - 1230 Discussion Period

1230 Lunch

1345 Departure from Northfield for New St. Station

Some of the officers of this establishment (all of whom we met, plus several others) are as follows:

Col. R. M. Rowlette, DSO, MC — Commanding Officer
Lt. Col. Thomas F. Main — Clinical Director
Lt. Col. I. Sutton — " "

Staff Members:

Major W. H. Whiles
" G. R. Peberdy
" R. E. D. Markillie
" S. H. Foulkes
" H. Bridger
" S. Cassells
" A. Thoms (Mrs.)
" E. M. Creak (Miss)
" S. Davidson (Miss)
" - Finlayson (Registrar) (33 years in the Army, 4 1/2 years in a German prison)

Captain John Cummings (Commando #3, in civil life a teacher at the Whitgift School, Croydon, England)
Captain Thomas Martin (psychologist)
Captain H. Gray (recreational therapy)
Captain L. A. Golding
Captain T. C. Lewson

On the evening of the first day a formal dinner was tendered the Commission by the staff of the hospital, at which toasts to the King and President were followed by short after-dinner comments by several members of the staff and of the Commission. Each member of the Commission was given a hand-printed menu card. The Commission was presented with several copies of the hospital newspapers, an editorial conference of which had previously been attended.

Reluctantly the Commission departed by train at 2:30 p.m., arriving in London just in time to keep an engagement for dinner with Doctor Edward Glover and with him, paying a visit to the home of Miss Anna Freud, where a paper was read by the Princess Maria Bonaparte of Paris, on Popular Fantasies and Myths Incident to War.

8 June 1945. "WOSB" 25. (War Officer Selection Board)

The use of psychiatry in the selection of officer candidate material was begun by Germany in 1936 and by the British in 1941. It is not yet in use in the United States Army. The history of the development of this project, details of its application and the results of its use over a period of four years were presented to the Commission at the Administrative Center, where technical research for selection and training of technical staff is carried on.

At this installation the officers were:

President	Col. R. S. Rait-Kerr, DSO, MC
Senior Psychiatrist	Lt. Col. J. D. Sutherland
	Lt. Col. John Bowlby
Psychologist	Major Ben Morris
	Major McFee Campbell
Psychologist (8th Army)	Major Dugmore Hunter
	Major - - FitzPatrick

The Commission did not have the opportunity to see a selection board in operation, as this would have taken three days, but instead in the late afternoon at the Shell Mex Oil Co. building, in their private movie theatre, it witnessed the uncut film which shows the actual workings of the boards. This was demonstrated by Mr. Geoffrey Bell and his assistant Miss Sarah Erulkar. Retired Lt. Col. John Rickmen, who participated in the filming of the scenes, joined with us in the viewing and in dinner afterwards. Lt. Col. Hargreaves was, much of the time, our escort.

9 June 1945. Mill Hill.

During the war, the British Army, Navy and Air Force arranged for the use of nine civilian hospitals with civilian staffs, to serve as "emergency medical service units". Some of these were psychiatric. The Mill Hill Emergency Hospital in North London is one of the most important of these, and since 1940 the bulk of its patients have been from the Army. The hospital was formerly under the direction of Dr. Walter Maclay, who resigned recently to take up a post as chairman of the Board of Control for the Mental Hospitals of the U. K. He was succeeded at Mill Hill by Dr. A. B. Stokes. In general the staff constituted that originally attached to Maudesley Hospital, of which Dr. Aubrey Lewis has been Acting Chief since the death of Dr. Mapother.

During the past five years this hospital has handled about 15,000 cases in its 550 beds, this includes some cases of civilians and children.

A pre-arranged program was presented to the Commission, consisting in part of an outline of psychological research and conducted by Dr. H. J. Eysenck and his associates Mrs. Himmelweit and Mrs. Petrie. This dealt with the distinction between neurotic and non-neurotic types and between two types of neuroticism (Janet), the anxious depressed type and the hysterical type. They have also done some interesting work in suggestibility tests, in group Rorschach tests, a modification of the Harrower Erickson multiple choice test, mosaic tests, graphology correlations, tract-testing tests, concentration tests and level of aspiration tests (using, in this connection, two ingenious machines). The staff of this hospital have also done some interesting research in the statistical recording and compiling of individual symptoms and elements in the history and examinations, using a hand sorting punch card device, samples of which were given to the Commission. A brief presentation of his experience in combat exhaustion cases was made by Dr. (formerly Major) M. N. Pal, M. B., B. S., M. R. C. P., D. C. H., D. P. H., D. T. M., D. P. M., of India (see the Lancet. August 12, 1944). Brief discussions were had with other members of the staff: Dr. Mabel Ross, an American psychiatrist from Buffalo, temporarily on duty here; Dr. - Fraser, who is specially interested in industrial psychiatry; Dr. - Gillespie who is specially interested in problems of children; Dr. - Guttman, specially interested in head injuries and officer selection; Dr. Maxwell Jones, who is specially interested in effort syndrome, group provision methods and nurses training and in prisoners of war; Dr. W. L. Rees who reported to the Commission on the physical methods of treatment of combat exhaustion and on narco-analysis, and Dr. - Whitby in charge of the industrial out-patient clinic.

The Commission was returned to the hotel and later taken to Kings Cross Station for the train to Edinburgh, Scotland.

10 June 1945. Edinburgh.

The Commission, minus one member who had to remain in England because of illness, and accompanies by Brigadier Rees, arrived in Edinburgh early Sunday morning, and repaired at once to North British Hotel. After breakfast and a walk along Princes Street, the Commission was

picked up by Col. Bruce and Major Gilroy of the Scottish Command, to pay a formal visit to the Surgeon and Consultant in Medicine of the Scottish Command. Then it was taken in cars across the Old Moat and up into Edinburgh Castle. By special arrangement (we were the only visitors at that time) the guide took us through the Castle and through the Scottish War Memorial. It was a bright, clear day and the experience made a memorable impression upon all of us.

After lunch at the hotel we were taken to see Holyrood and part of the famous Royal Mile, also passed Edinburgh University and Medical School and several hospitals. We stopped for tea at the home of Professor J. K. Henderson, head of the Department of Psychiatry at the University of Edinburgh, where, in addition to Dr. and Mrs. Henderson, his daughters and some others, we also met Dr. J. L. Halliday, a well known public health officer and head of the Department of Public Health in Glasgow. Mr. Norman Dott (neuro-surgeon) and his assistants Mr. Alexander and Dr. Patterson. Clinical aspects and impressions and attitudes were discussed with Drs. Henderson and Halliday and various members of the Commission, and all enjoyed the gracious hospitality and beautiful gardens.

The Commission was entertained at dinner and afterwards in the hotel by members of the Royal Scottish Command, and in particular the staff of the Bellsdyke Hospital. These were as follows:

Commadning Officer	Lt. Col. H. B. Craigie
	Lt. Col. C. D. Bruce
	Major E. H. Rosenberg (wife of Dr. Guttmann)
	Major R. K. Grossart
	Major M. Lillie
	Major W. Hosie
	Major John Gilroy

11 June 1945.

We were met at breakfast by Brig G. W. B. James, who had come up from London to spend the day with us and shortly after breakfast the party started West in two cars, passing through Donne to Aberfoyle, thence north by the Trossachs and around one of the lakes, back to Callender, thence to Bellsdyke, where we were given a hearty welcome by the staff, an excellent dinner of freshly caught salmon trout,

a brief clinical program report on the work of the hospital, a pleasant tea and an inspection tour through the hospital.

Major Rosenberg discussed the psychonathology of War Neuroses and their treatment from an analytic point of view and described an insulin program in which good results are attained through the use of very small doses of this drug in selected cases. Major Hosie discussed his clinical studies of over 500 psychopathic personalities during tea time.

The work of this institution is characterized by the elaborate, ingenious occupational therapy program, and the clinical skill and leadership of Col. Craigie, who, in the earlier years of the war commanded a psychiatric center in the Middle East.

Members of the staff were as follows:

Lt. Col. H. B. Craigie
Major William Hosie
Major R. K. Grossart
Dr. W. R. D. Fairburn
Major Elizabeth Rosenberg
Dr. Kate Frazer (Scottish Board of Control)
Lt. Col. C. S. Bruce (Carstairs Military Hospital)
Major Malcolm Miller (W.O.S.B. 1)

The personal charm and friendliness of our Scottish hosts, and the beautiful scenery contributed to making this a very pleasant stay. On the way back to Edinburgh a stop was made at Linlithgow Castle, where a devoted guide, Mr. Chandler, took great pains to give us an intimate, and at the same time, comprehensive impression of this beautiful and historic ruin.

Brig. W. Stephenson and Dr. Fairburn joined us at dinner and we went to our sleepers at nine o'clock.

12 June 1945. London.

The morning was spent in viewing three excellent documentary and educational Army films at the Army 35 mm projection theatre in the Curzon Street house.

1. "On the Face of It" – a film for overseas troops showing the changes that have taken place in everyday life in England.

2. Film showing various "pubs" and pub-life in England, intended originally to give the soldiers a home-like feeling, but sometimes critized as being so successful in this direction as to create nostalgie.

3. An excellent film showing methods of personal selection for the British army in what is equivalent to our induction boards.

In the afternoon two members of the Commission visited Miss Anna Freud at the Hampstead Nursery, which she and Miss Burlingham have been conducting for war-orphaned children in England. The three others were conducted by Lt. Col. Hargreaves to the Houses of Parliament at Westminister, where, with great difficulty, arrangements had been made for admission to the Visitors' Gallery of the House of Commons (which meets in the hall of the House of Lords because the original House of Commons was destroyed by a bomb). The Commission arrived in time to see the Speaker's Procession, although the Speaker himself, by rare exception, was absent, the reason being that General Eisenhower had come to town and the Speaker had gone to greet him. The Commission was also fortunate in seeing a rather exciting "uproar" in the House of Commons, participated in by Mr. Churchill.

At eight o'clock, the entire Commission, plus Col. Lloyd Thompson, were the guests of Director General, Sir Alexander Hood of the Army Medical Service and his associates:

Brigadier Sandiford
" Rees
" James
Lt. Col. Hargreaves
" Copeland
" Sutherland

After a very fine dinner with appropriate toasts and short formal speeches, an informal social visit lasted until nearly midnight. Transportation in London during war-time is such that all meetings must terminate before midnight. The dinner was held at Claridge's Hotel, Brook Street, W. 1.

13 June 1945.

Officers of the Royal Naval Medical Department had previously told Brigadier Rees of their wish to entertain

the Commission and it had originally been sugrested, if not actually arranged that we visit Cholmondeley Castle, near Livernool, where a nsychiatric convalescent center is maintained. Our time seemed too short to permit of this, however, so it was arranged that we visit the hosnital and barracks at Chatham. The navy maintains three large land barracks, each housing approximately 40,000 sailors, and one of these is located at Chatham, about 25 miles down the river from London. At this same place there is a Naval hospital, separate from the barracks. We visited the latter first, accompanied by our escort, Surgeon Captain Desmond Curran, and were greeted by Surgeons Lt. Commander Butler and Lt. Harley. After looking over some case records of nsychiatric patients and visiting a few wards, we left the hosnital for the barracks where we met Surgeon Captain W. G. Thwaytes, the Commanding Officer, and two nsychiatrists, Surgeon Lt. Cmdr. Paul Mallinson, R.N.V.R. and Surgeon Lt. Cmdr. L. Warren, R.N.V.R. An excellent lunch was served in a private dining room, following which we conferred with Capt. Curran and the two medical officers for several hours. They told us a great deal about snecial nsychiatric nroblems of Navy life and Naval combat and their clinical experience as nsychiatrists to the incoming sailors and sailors reassigned to sea duty, and the nsychiatric casualties snecially referred to them from ships and other posts.

The return trip was made along the Maidstone Road, a little further down in Kent then the outgoing route. We arrived back in London in time to nrenare for a dinner given to the Commission by the Council of the British Psychoanalytic Society.

14 June 1945. Oxford (R.A.F.)

In accordance with arrangements made by Brigadier Rees and Lt. Col. Hargreaves with Air Chief Marshal C. R. Symonds (Queen's Square and Guy's Hospitals), we were conveyed by an Air Force car from the Hotel to the Army's Head Injuries Hospital at Oxford, 60 miles N. E. of London. The Army and the Air Force are entirely separate organizations in the British War Department, but in this instance Chief Marshal Symonds and his assistant, Wing Commander Denis Williams, are nermitted to occupy a nart of the Army's hospital in exchange, as it were, for their consultant services. The chief task of Symonds and Williams consists in the direction of the nsychiatric work of the R.A.F. They had carefully nrenared material nertaining to their nsychiatric experience, policies, methods and results, and gave these to the

Commission very fully and clearly, enabling us to make useful comparisons between the British and American Air Forces psychiatry on the one hand and Air Force and Ground Force psychiatry on the other. A newly arrived patient was examined by Dr. Symonds before the Commission and served as the basis for a long and very helpful discussion.

In the course of the day we met and had lunch with Major W. R. Raynell, psychiatrist, Lt. Col. L. S. C. Roche, D. O., (who had been 30 years in the Army) and several neurosurgeons whose names we did not get, who work in the Army's Brain Injuries Hospital under Brig. Cairns, who happened to be absent on the day of our visit. Several interesting brain injury cases were seen by the Commission on the wards. We were taken to dinner in the evening in a 500 year old restaurant "The Mitre", and were then conducted through one of the old colleges in which Dr. Symonds is a Senior Fellow. We returned to London by midnight.

15 June 1945.

One member of the Commission (J. R.) set out for Bristol to visit Mr. Grey Walter, who is in charge of the Electroencephalographic unit of the Burden Neurological Institute of that city. He had the opportunity to discuss methods and equipment of electroencephalography and to learn a great deal of the progress which has taken place in England in this field of study.

15 June to 29 June 1945. London.

Preparation of Commission's Report.

29 June 1945.

London to Paris by plane.

30 June 1945. Paris. (Hotel Roblin)

Much of the day was spent on final revisions of the report by four members of the Commission; the fifth member of the Commission had left London two days previously on a special errand. In the evening the members of the Commission were the guests of Col. Ernest Parsons, now Commanding Officer of the 108th General Hospital. Other guests were Col. Lloyd Thompson, Major Douglas Kelley and Major George Perkins.

1 July 1945. Paris. (Sunday)

In addition to some further work on the report the members of the Commission were the guests of Col. Lloyd Thompson in his apartment during the late afternoon and evening. Col. William Middleton was also present.

2 July 1945. Paris.

The morning was spent in additional work on the report. At 11:30 the members of the Commission were taken by automobile to the 191st General Hospital in the suburb of Paris known as Villejuif. We were hospitably received by the new Commanding Officer, Col. Paul Hayes, and by the psychiatrists, Lt. Col. Lewis Loeser (who is now running the School) Major Roy Swank, and Major Edward Greenwood (detached service). The Commission was told in detail about the 28 day School for Battalion Aid Surgeons and young psychiatrists conducted by Colonel Loeser and were given the opportunity to discuss with some thirty of these Captains and Majors various aspects of their experience, with special reference to combat exhaustion and the criteria for deciding what disposition to make of a patient appearing at a Battalion Aid Station. Various wards of the Hospital were inspected, some patients examined briefly, and an adjoining (French) psychiatric hospital briefly visited. A very helpful conference was held in the evening with Major Edward Greenwood.

3 July 1945.

Early in the morning a conference with General Hawley was attended by three members of the Commission. (The other two members of the Commission did not receive notification.) General Hawley was very interested in the general substance of the findings of the Commission and expressed a wish for a final report.

In the evening two members of the Commission discussed problems of Army Hospital nursing at some length with two nursing officers at the Casual Officers Mess. The final work was done on the report and arrangements made by Chairman Bartemeier to place it in special mail sacks for transportation to the United States.

4 July 1945.

The Commission was impressed by the absence of many American flags on the stores and public buildings. Coffee and other refreshments were offered free at the American Red Cross installations which was our only celebration of

the holiday. A cable was received from the Surgeon General's Office urging the expedition of our return. Final mail received on this day.

Dinner and the evening was spent with Lt. Col. Fred Hansen, Chief Psychiatric Consultant for the Mediterranean Theater. He was able to confirm and extend various impressions and added some additional information of importance.

5 July 1945. Paris.

As a result of the thoughtfulness and courtesy of Major Pierre Turquet of the British Army Medical Department, himself a psychiatrist but assigned to liaison work with the French because of his versatility in French and other languages, the Commission lunched at the George V Hotel with Col. Jean Benedetti, the Director General of the French Army Medical Corps.

In the evening also by virtue of the courtesy of Major Turquet the Commission met Professor Jean Delay, Professor of Psychiatry at the University of Paris, and after some drinks with him at the Hotel Lafayette were conveyed to the home of the Viscount Jacques de Canson where we met in addition to Count Canson the Marquis Pagan, Mrs. Delay, Professor l'Hermitte, and Doctors Schlumberger, Parcheminey and Heuger. The home contained many magnificent specimens of art. The meeting represented the efforts of an association organized for the improvement of American-French relations. In that direction and in others the evening was very successful.

6 July 1945. Paris.

Still conducted by Major Turquet, the Commission met several young psychiatric students in the morning, then went to the Salpetriere and to St Anne's; in the latter hospital Doctor Delay and his staff, including some of the colleagues met the night before, demonstrated some patients and gave the members of the Commission some scientific reprints.

Major Turquet had arranged for us to have cocktails with Professor Pierre Janet but orders were suddenly received for the Commission to be at the A. T. C. office at 5 o'clock so that this appointment had to be cancelled.

At 11 p.m. our plane left for the Azores.

7 July 1945. To the Azores and to U. S. A.

After breakfast at the Azores we were informed that four of the Commission would have to transfer to another plane, Chairman Bartemeier going on in the original C-54. The rest of us followed in a C 54-E with thirty-five sergeants and other enlisted men whose dignity, good manners, poise and spirit endeared them to all of us. After a very smooth trip by an excellent pilot we reached Newfoundland in the evening; it was too foggy to land there so we went on to Presque Isle, Maine where we had supper and then on to Wilmington, Delaware where we arrived at 1 a.m. on 8 July.

8 July 1945. Washington.

We went by train from Wilmington to Washington and were met at the Union Station by Chairman Bartemeier. We then went to the Cosmos Club for a few hours of sleep.

9 July 1945. Washington.

Official report was made by the Commission to the Surgeon General's Office in the morning.

In the evening four members of the Commission worked until midnight on some additional revisions of the report.

10 July 1945. Washington.

In the forenoon, oral report of the Commission was made to the office of Field Service of the office of Scientific Research and Development. In the afternoon, additional reports were made by the Commission to the Surgeon General's Office.

On this evening some members of the Commission departed; others made some additional changes in the report and departed on 11 July 1945 to await the retyping of the report in preparation for the final copies.

16-18 July 1945.

On these dates the contracts of the members of the Commission with the O S R D officially terminated.

APPENDIX - B

VISIT TO THE BURDEN NEUROLOGICAL INSTITUTE, BRISTOL

By Dr. John Romano

June 15th 1945

Purpose of the visit: to meet and talk with Mr. W. Grey Walter, who is in charge of the Department of Electroencephalography.

The Burden Neurological Institute is a recently organized neurological hospital equipped to do neurophysiologic, neurologic and neurosurgical research and clinical work. At the beginning of the war it was taken over by the E.M.S., and has served as a head injury hospital for both civilian and military personnel. My purpose in visiting the Institute was not to learn anything concerning present clinical neurological and neurosurgical procedures, but rather to learn from Mr. Grey Walter something of the methods and technical equipment he has introduced in the field of electroencephalography. I had occasion to spend three hours with Mr. Walter and with his associates Miss V. J. Dovey and Mr. G. R. Baldock. Miss Dovey is the technical assistant, and Mr. Baldock is the electrical engineer who has played an important part in the construction of the various machines used.

It appears that Mr. Grey Walter has been concerned with EEG problems similar to those we face in America. It has been possible for the specialists in this field in England to meet often and to reach certain conclusions as to standards of method and interpretation of the electroencephalogram. A national EEG Society has been created, and it has been possible through the Society to outline clearly to the members certain criteria of EEG abnormality and to enumerate a glossary of terms used in EEG practice and interpretation. In addition, the Society has provided a list of the major contributions to the literature as well as unpublished reports. They have formed a committee to suggest technical recommendations on apparatus. They are also engaged in preparing a syllabus for training technicians, physiologists and clinicians.

One of Grey Walter's principal concerns has been the scope and limitations of visual analyses of the electroencephalogram. He and his co-workers have introduced a low frequency analyser, and a low frequency photomechanical oscillator. With the latter instrument, it is possible to mimic accurately the various wave forms that occur in the EEG. The ability to produce these effects without the distractions of the repeated changes occurring in the natural EEG has proved of great value they believe in visualizing the way in which a given wave in the EEG may be expected to change in altered physiologic conditions. They believe, in addition, that this instrument provides a useful

check on the accuracy of an analysis of the EEG.

My training does not allow me to be critical in the appraisal of the mechanical aspects of either the analyser or the photo-mechanical oscillator. However, in our work to date, we have felt the limitations of visual inspection and arithmetical count in the analysis of EEG. If both of these machines prove to be practical and can be produced, they may be of considerable value for certain research units; they may lead to a much clearer understanding of the nature of the electrical potentials which are recorded by the EEG.

Mr. Grey Walter also demonstrated to me the two channel portable instrument which is being prepared for military purposes. If there is a need for this in the American military forces, I would suggest that the interested persons communicate with Mr. Grey Walter. As I remember, they are to be manufactured by the Marconi Instrument Company, St. Albans.

Although Mr. Grey Walter is not a physician and is principally a physiologist with special skills and interests in the field of electrophysiology, it was my impression that his grasp and understanding of the role of electroencephalography in clinical research was both sound and stimulating. From what he and others have told me, his laboratory has worked intimately with some of the American military hospitals in England.

The following is a list of publications of work in this field recently completed by Grey Walter and his associates:

1. GREY WALTER, W.

An Automatic Low Frequency Analyses.
Electronic Engineering, June 1943.
(Bress at Coombelands Ltd., Addlestone & London)

2. GREY WALTER, W.

An Improved Low Frequency Analyses.
Electronic Engineering, November 1943.

3. BALDOCK, G. R. and W. GREY WALTER

Low Frequency Photo-Mechanical Oscillators.
Electronic Engineering, March 1945.

4. GREY WALTER, W. and DOVEY, V. J.

Electroencephalography in Cases of Subcortical Tumor.
Journal of Neurology, Neurosurgery and Psychiatry.
7:57, July and October 1944.

5. DAWSON, G. D. and W. GREY WALTER

The Scope and Limitations of VISUAL and AUTOMATIC
Analysis of The Electroencephalogram.
Journal of Neurology, Neurosurgery and Psychiatry.
7:119, July and October 1944.